OMB Number: 4040-0004
Expiration Date: 03/31/2012

Application for Federal Assistance SF-424

* 1. Type of Submission:	* 2. Type of Application:	* If Revision, select appropriate letter(s):
☐ Preapplication	☐ New	
☒ Application	☒ Continuation	* Other (Specify):
☐ Changed/Corrected Application	☐ Revision	

* 3. Date Received:	4. Applicant Identifier:
11/01/2011	

5a. Federal Entity Identifier:	5b. Federal Award Identifier:
	H89HA00036

State Use Only:

6. Date Received by State:	7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name:	City of Austin Health and Human Services Department (HHSD)

* b. Employer/Taxpayer Identification Number (EIN/TIN):	* c. Organizational DUNS:
74-6000085	9456072650000

d. Address:

* Street1:	7201 Levander Loop, Building E
Street2:	
* City:	Austin
County/Parish:	
* State:	TX: Texas
Province:	
* Country:	USA: UNITED STATES
* Zip / Postal Code:	78702-5168

e. Organizational Unit:

Department Name:	Division Name:
Austin/Travis County HHSD	Community Services Division

f. Name and contact Information of person to be contacted on matters Involving this application:

Prefix:	Mr.	* First Name:	Gregory
Middle Name:	L.		
* Last Name:	Bolds		
Suffix:			

Title:	Manager, HIV Resources Administration Unit
Organizational Affiliation:	Austin/Travis County HHSD

* Telephone Number:	512-972-5081	Fax Number:	512-972-5082
* Email:	gregory.bolds@austintexas.gov		

Application for Federal Assistance SF-424

*** 9. Type of Applicant 1: Select Applicant Type:**

C: City or Township Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

Health Resources & Services Administration

11. Catalog of Federal Domestic Assistance Number:

93.914

CFDA Title:

HIV Emergency Relief Project Grants

*** 12. Funding Opportunity Number:**

HRSA-12-128

* Title:

Ryan White Part A HIV Emergency Relief Grant Program

13. Competition Identification Number:

5085

Title:

14. Areas Affected by Project (Cities, Counties, States, etc.):

AreasAffectedbyProject.doc | Add Attachment | Delete Attachment | View Attachment

*** 15. Descriptive Title of Applicant's Project:**

Ryan White HIV/AIDS Treatment Extension Act of 2009 Part A, including MAI, HIV Emergency Relief Grant Program for the Austin Transitional Grant Area. Project Abstract attached.

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

Areas Affected by Project

City of Austin, Counties of Bastrop, Caldwell, Hays, Travis, and Williamson, located in the State of Texas

Project Abstract

Ryan White HIV/AIDS Treatment Extension Act of 2009 Part A, including MAI
HIV Emergency Relief Grant Program; HRSA Grant Number H89HA00036
City of Austin, Austin/Travis County Health and Human Services Department
7201 Levander Loop, Bldg. E, Austin, Texas 78702-4101
(512) 972-5081 Voice; (512) 972-5082 Fax
gregory.bolds@austintexas.gov

Located in central Texas, the Austin Transitional Grant Area (TGA) covers 4,281 square miles and encompasses the five counties of Bastrop, Caldwell, Hays, Travis, and Williamson. The Austin TGA, which is about 40 percent larger than Rhode Island and Delaware combined, has a population of almost 1.8 million in 2011. As one of the fastest growing areas in the United States, it has a third more residents than 10 years ago and double the population of 20 years ago. The racial/ethnic distribution is as follows: 53.3% White; 33.7% Hispanic; 7.8% African American; and 5.1% reported as Other. The TGA is predominately young; 67.6% of all persons are less than 45 years old.

The number of persons living with HIV in the Austin TGA continues to increase every year. As of December 31, 2010, there were 1,791 persons living with HIV (not AIDS) and 2,561 persons living with AIDS in the TGA. The demographic characteristics of persons with HIV/AIDS in the TGA continue to change, indicating a shift in the populations most affected by HIV/AIDS. Although comprising only 7.8% of overall population, African Americans accounted for 22.3% of new HIV cases and 21.1% of new AIDS cases for the period 2009-2010. Of all HIV/AIDS cases diagnosed in the TGA for the two-year period 2009-2010, 84% were reported within Travis County. HIV services providers, primarily located along the Interstate Highway 35 corridor in the TGA, offer service facilities that are accessible to the TGA's underserved populations. African American and Hispanic are the two populations served with Minority AIDS Initiative (MAI) funds.

Under the Ryan White HIV/AIDS Treatment Extension Act of 2009 Part A and MAI HIV Emergency Relief Grant Program, the Austin TGA has developed a coordinated service delivery system with a comprehensive range of services for persons living with HIV infection, in order to meet their primary medical care and related needs throughout all stages of disease. Although this continuum of care is largely supported with Ryan White Program funds, it also relies on additional support from multiple funding sources including local city and county funding.

The Austin Area Comprehensive HIV Planning Council has set priorities and allocated funds for FY 2012 to HIV service categories that address the growing number of clients with more complex disease, inadequate knowledge of HIV, and multiple socio-economic problems. The priority core medical services for FY 2012 include outpatient/ambulatory medical care, local AIDS pharmaceutical assistance, oral health care, medical case management, mental health services, and outpatient substance abuse services, as well as non-medical case management, outreach services, and other health-related support services designed to facilitate access to and retention in care. The Austin TGA has received Ryan White Program Title I/Part A funding for seventeen (17) years and MAI funding for thirteen (13) years.

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant: 10th
b. Program/Project: 10th

Attach an additional list of Program/Project Congressional Districts if needed.

AdditionalCongressionalDistricts.doc | Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date: 03/01/2012
* b. End Date: 02/28/2013

18. Estimated Funding ($):

* a. Federal	4,400,041.00
* b. Applicant	0.00
* c. State	0.00
* d. Local	0.00
* e. Other	0.00
* f. Program Income	100,000.00
* g. TOTAL	4,500,041.00

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

[X] a. This application was made available to the State under the Executive Order 12372 Process for review on 10/28/2011.

[ ] b. Program is subject to E.O. 12372 but has not been selected by the State for review.

[ ] c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes," provide explanation in attachment.)**

[ ] Yes [X] No

If "Yes", provide explanation and attach

Add Attachment | Delete Attachment | View Attachment

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)**

[X] ** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix: Honorable
* First Name: Lee
Middle Name:
* Last Name: Leffingwell
Suffix:

* Title: Mayor

* Telephone Number: 512-974-2250
Fax Number: 512-974-2337

* Email: lee.leffingwell@austintexas.gov

* Signature of Authorized Representative: Leslie Boyd
* Date Signed: 11/01/2011

Additional List of Program/Project Congressional Districts

Additional Congressional Districts of Applicant

21st
25th

Additional Congressional Districts of Program/Project

15th
21st
25th
28th
31st

OMB Approval No. 0990-0317
Expiration Date: 8/31/2010

CHECKLIST

NOTE TO APPLICANT: This form must be completed and submitted with the original of your application. Be sure to complete each page of this form. Check the appropriate boxes and provide the information requested. This form should be attached as the last pages of the signed original of the application.

Type of Application: ☐ New ☐ Noncompeting Continuation ☒ Competing Continuation ☐ Supplemental

PART A: The following checklist is provided to assure that proper signatures, assurances, and certifications have been submitted.

	Included	NOT Applicable
1. Proper Signature and Date on the SF 424 (FACE PAGE)	☒	
2. If your organization currently has on file with HHS the following assurances, please identify which have been filed by indicating the date of such filing on the line provided. (All four have been consolidated into a single form, HHS 690)		
☒ Civil Rights Assurance (45 CFR 80)	06/10/1991	
☒ Assurance Concerning the Handicapped (45 CFR 84)	06/10/1991	
☒ Assurance Concerning Sex Discrimination (45 CFR 86)	06/10/1991	
☐ Assurance Concerning Age Discrimination (45 CFR 90 & 45 CFR 91)		
3. Human Subjects Certification, when applicable (45 CFR 46)	☐	☒

PART B: This part is provided to assure that pertinent information has been addressed and included in the application.

	YES	NOT Applicable
1. Has a Public Health System Impact Statement for the proposed program/project been completed and distributed as required?	☐	☒
2. Has the appropriate box been checked on the SF-424 (FACE PAGE) regarding intergovernmental review under E.O. 12372 ? (45 CFR Part 100)	☒	
3. Has the entire proposed project period been identified on the SF-424 (FACE PAGE)?	☒	
4. Have biographical sketch(es) with job description(s) been provided, when required?	☒	☐
5. Has the "Budget Information" page, SF-424A (Non-Construction Programs) or SF-424C (Construction Programs), been completed and included?	☒	
6. Has the 12 month narrative budget justification been provided?	☒	☐
7. Has the budget for the entire proposed project period with sufficient detail been provided?	☒	☐
8. For a Supplemental application, does the narrative budget justification address only the additional funds requested?	☐	☒
9. For Competing Continuation and Supplemental applications, has a progress report been included?	☐	☒

PART C: In the spaces provided below, please provide the requested information.

Business Official to be notified if an award is to be made

Prefix: Ms. First Name: Kymberley Middle Name:
Last Name: Maddox Suffix:
Title: Chief Administrative Officer
Organization: City of Austin HHSD
Street1: 7201 Levander Loop, Building H
Street2:
City: Austin
State: TX: Texas ZIP / Postal Code: 78702 ZIP / Postal Code4: 5168
E-mail Address: kymberley.maddox@austintexas.gov
Telephone Number: 512-972-5041 Fax Number: 512-972-5033

Program Director/Project Director/Principal Investigator designated to direct the proposed project or program.

Prefix: Mr. First Name: Gregory Middle Name: L.
Last Name: Bolds Suffix:
Title: Manager
Organization: City of Austin HHSD
Street1: 7201 Levander Loop, Building E
Street2:
City: Austin
State: TX: Texas ZIP / Postal Code: 78702 ZIP / Postal Code4: 5168
E-mail Address: gregory.bolds@austintexas.gov
Telephone Number: 512-972-5081 Fax Number: 512-972-5082

PART D: A private, nonprofit organization must include evidence of its nonprofit status with the application. Any of the following is acceptable evidence. Check the appropriate box or complete the "Previously Filed" section, whichever is applicable.

☐ (a) A reference to the organization's listing in the Internal Revenue Service's (IRS) most recent list of tax-exempt organizations described in section 501(c)(3) of the IRS Code.

☐ (b) A copy of a currently valid Internal Revenue Service Tax exemption certificate.

☐ (c) A statement from a State taxing body, State Attorney General, or other appropriate State official certifying that the applicant organization has a nonprofit status and that none of the net earnings accrue to any private shareholders or individuals.

☐ (d) A certified copy of the organization's certificate of incorporation or similar document if it clearly establishes the nonprofit status of the organization.

☐ (e) Any of the above proof for a State or national parent organization, and a statement signed by the parent organization that the applicant organization is a local nonprofit affiliate.

If an applicant has evidence of current nonprofit status on file with an agency of HHS, it will not be necessary to file similar papers again, but the place and date of filing must be indicated.

Previously Filed with: *(Agency)* on *(Date)*

INVENTIONS

If this is an application for continued support, include: (1) the report of inventions conceived or reduced to practice required by the terms and conditions of the grant; or (2) a list of inventions already reported, or (3) a negative certification.

EXECUTIVE ORDER 12372

Effective September 30, 1983, Executive Order 12372 (Intergovernmental Review of Federal Programs) directed OMB to abolish OMB Circular A-95 and establish a new process for consulting with State and local elected officials on proposed Federal financial assistance. The Department of Health and Human Services implemented the Executive Order through regulations at 45 CFR Part 100 (Inter-governmental Review of Department of Health and Human Services Programs and Activities). The objectives of the Executive Order are to (1) increase State flexibility to design a consultation process and select the programs it wishes to review, (2) increase the ability of State and local elected officials to influence Federal decisions and (3) compel Federal officials to be responsive to State concerns, or explain the reasons.

The regulations at 45 CFR Part 100 were published in the Federal Register on June 24, 1983, along with a notice identifying the Department's programs that are subject to the provisions of Executive Order 12372. Information regarding HHS programs subject to Executive Order 12372 is also available from the appropriate awarding office.

States participating in this program establish State Single Points of Contact (SPOCs) to coordinate and manage the review and comment on proposed Federal financial assistance. Applicants should contact the Governor's office for information regarding the SPOC, programs selected for review, and the consultation (review) process designed by their State.

Applicants are to certify on the face page of the SF-424 (attached) whether the request is for a program covered under Executive Order 12372 and, where appropriate, whether the State has been given an opportunity to comment.

BY SIGNING THE FACE PAGE OF THIS APPLICATION, THE APPLICANT ORGANIZATION CERTIFIES THAT THE STATEMENTS IN THIS APPLICATION ARE TRUE, COMPLETE, AND ACCURATE TO THE BEST OF THE SIGNER'S KNOWLEDGE, AND THE ORGANIZATION ACCEPTS THE OBLIGATION TO COMPLY WITH U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES' TERMS AND CONDITIONS IF AN AWARD IS MADE AS A RESULT OF THE APPLICATION. THE SIGNER IS ALSO AWARE THAT ANY FALSE, FICTITIOUS, OR FRAUDULENT STATEMENTS OR CLAIMS MAY SUBJECT THE SIGNER TO CRIMINAL, CIVIL, OR ADMINISTRATIVE PENALTIES.

THE FOLLOWING ASSURANCES/CERTIFICATIONS ARE MADE AND VERIFIED BY THE SIGNATURE OF THE OFFICIAL SIGNING FOR THE APPLICANT ORGANIZATION ON THE FACE PAGE OF THE APPLICATION:

Civil Rights – Title VI of the Civil Rights Act of 1964 (P.L. 88-352), as amended, and all the requirements imposed by or pursuant to the HHS regulation (45 CFR part 80).

Handicapped Individuals – Section 504 of the Rehabilitation Act of 1973 (P.L. 93-112), as amended, and all requirements imposed by or pursuant to the HHS regulation (45 CFR part 84).

Sex Discrimination – Title IX of the Educational Amendments of 1972 (P.L. 92-318), as amended, and all requirements imposed by or pursuant to the HHS regulation (45 CFR part 86).

Age Discrimination – The Age Discrimination Act of 1975 (P.L. 94-135), as amended, and all requirements imposed by or pursuant to the HHS regulation (45 CFR part 91).

Debarment and Suspension – Title 2 CFR part 376.

Certification Regarding Drug-Free Workplace Requirements – Title 45 CFR part 82.

Certification Regarding Lobbying – Title 32, United States Code, Section 1352 and all requirements imposed by or pursuant to the HHS regulation (45 CFR part 93).

Environmental Tobacco Smoke – Public Law 103-227.

Program Fraud Civil Remedies Act (PFCRA)

Project Narrative File(s)

*** Mandatory Project Narrative File Filename:** AustinTGAProjectNarrativeFY12.pdf

Add Mandatory Project Narrative File | Delete Mandatory Project Narrative File | View Mandatory Project Narrative File

To add more Project Narrative File attachments, please use the attachment buttons below.

Add Optional Project Narrative File | Delete Optional Project Narrative File | View Optional Project Narrative File

Table of Contents: Project Narrative

1) Demonstrated Need

1) A. HIV/AIDS Epidemiology

Demographic Characteristics of General Population in the TGA

Almost 1.8 million people reside in the Austin Transitional Grant Area (TGA) and the majority (57.3%) lives in Travis County. The TGA is predominately White (53.3%) and young; 67.6% of all persons are less than 45 years old. The racial/ethnic composition of the TGA is slowly changing. In 2000, White non-Hispanics accounted for 61.5% of the population and Hispanics 26.2%. In 2011, Hispanics comprise 33.7% (Table B). In 2000, 20.3% of Spanish-speaking households were linguistically isolated; by 2010, a total of 31,893 Spanish-speaking households or 23.1% were linguistically isolated (source: *US Census Bureau, 2010 American Community Survey*). Over two-thirds (68.2%) of all African American TGA residents live in Travis County; similarly, 76.6% of all individuals of other races/ethnicities reside in Travis County.

Table A: Distribution of the Austin TGA general population, by sex and age, 2011.

Age (yrs)	Male (N=911,268)	Female (N=853,742)	Total (N=1,765,010)
0-12	152,187	147,729	299,916
13-19	81,984	78,057	160,041
20-44	393,904	338,466	732,370
≥45	283,193	289,490	572,683

Source: *Texas State Data Center & Office of the State Demographer, 2011.*

Table B: Percentage distribution of Austin TGA population by race/ethnicity and county, 2011.

Race/ Ethnicity	Bastrop N=84,458	Caldwell N=39,415	Hays N=171,682	Travis N=1,011,063	Williamson N=458,392	TGA N=1,765,010
White	58.9	43.0	61.8	45.5	67.3	53.3
African American	8.2	8.7	3.4	9.3	6.0	7.8
Hispanic	32.0	47.6	33.3	38.4	22.9	33.7
Other	0.9	0.8	1.6	6.8	3.8	5.1

Source: *Texas State Data Center & Office of the State Demographer, 2011.*

Table C: HIV cases & rates per 100,000 among persons in Austin TGA, by race/ethnicity and sex, diagnosed 2009-2010.

	Males			Females			Total		
Race/ethnicity	N	%	Rate	N	%	Rate	N	%	Rate
White	175	45.1	18.9	24	34.8	2.6	199	43.5	10.8
African American	75	19.3	57.0	27	39.1	20.3	102	22.3	38.6
Hispanic	127	32.7	21.4	17	24.6	3.3	144	31.5	13.0
Asian-Pacific Is.& Multiracial	11	2.8	13.0	1	1.4	1.2	12	2.6	7.2
Total	388	100.0	22.3	69	100.0	4.2	457	100.0	13.5

Source: *Texas eHARS (unadjusted for reporting delays), 2011.*

HIV/AIDS Cases by Demographic Characteristics and Exposure Categories

During 2009-2010, HIV infection was diagnosed for 457 persons of whom 84.9% were male and 15.1% were female (Table C). For this two year period, less than half of newly diagnosed HIV cases were White non-Hispanic (43.5%), almost one quarter were African American (22.3%), and 31.5% were Hispanic. Rates were significantly higher among African Americans, approximately four times higher than among both Whites and Hispanics. Table D shows that the distribution of risk differs by race/ethnicity in the TGA. The most common risk factor was male-to-male sexual contact (69.8%) for all races/ethnicities. Among African Americans (47.8%), Hispanics (75.0%), and Whites (78.7%), most new HIV cases were in the male-to-male sexual contact exposure category.

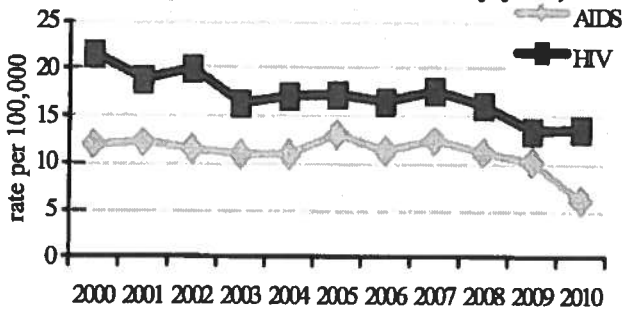
Table D: HIV cases among persons in the Austin TGA, by exposure category and race/ethnicity, diagnosed 2009-2010.

	White		African American		Hispanic		Asian-PI & Multi racial		Total	
Exposure Category	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Male-to-male sex	157	78.7	49	47.8	104	72.3	9	75.0	319	69.8
Injection drug use	10	5.1	15	15.1	9	5.9	1	8.3	35	7.7
MSM & IDU	12	6.1	2	1.7	5	3.5	1	8.3	19	4.2
Heterosexual	20	10.2	34	33.5	26	18.3	1	8.3	82	18.0
Pediatric	0	0	2	2.0	0	0.0	0	0	2	0.4
Adult Other	0	0	0	0.0	0	0.0	0	0	0	0.4
Total	199	100.0	102	100.0	144	100.0	12	100	457	100.0

Source: *Texas eHARS (risk statistically redistributed), 2011.*

The unadjusted rates of newly diagnosed HIV and AIDS cases decreased slightly from 2009 to 2010 (Figure 1). This may be a result of extensive cleaning and updating of the Texas HIV/AIDS Reporting System (HARS). Texas transitioned to a new surveillance system (HARS to eHARS) in 2009, which affected all years of data. Additionally, several other de-duplication and death updates were performed. Subsequently, many records were deleted from Texas eHARS because they represented deceased cases, were duplicate records, represented out-of-state cases, changed diagnostic status to seroreverters, or the cases' respective race could not be confirmed. Approximately 84% of all newly diagnosed cases of HIV and AIDS were reported in Travis County, and the county accounts for about 57% of the TGA population.

Figure 1: Rate per 100,000 of Diagnosed HIV and AIDS by year, Austin TGA 2000-2010.



Source: *Texas eHARS (unadjusted for reporting delays), 2011.*

In 2009-2010, according to Texas eHARS, a total of 270 new AIDS cases were diagnosed. About 82% of those cases were male. By race/ethnicity, 43.7% of cases were White non-Hispanic, 21.1% of cases were African American, and 32.6% were Hispanic. The highest rates of cases were among African American males and females, which were substantially higher than rates among White non-Hispanics (Table E).

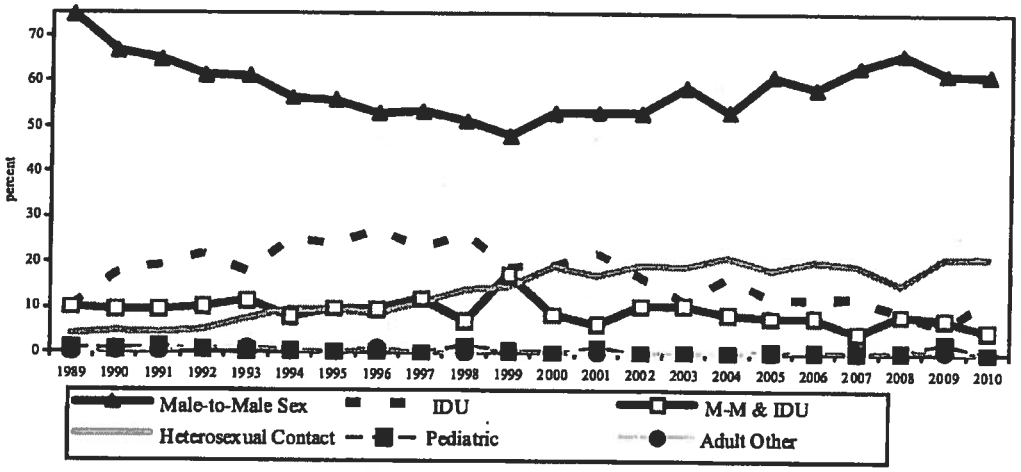
Table E: AIDS cases and rates per 100,000 among persons in Austin TGA, by race/ethnicity & sex, diagnosed 2009-2010.

	Males			Females			Total		
Race/ethnicity	**N**	**%**	**Rate**	**N**	**%**	**Rate**	**N**	**%**	**Rate**
White	103	46.4	11.1	15	31.3	1.6	118	43.7	6.4
African American	38	17.1	28.9	19	39.6	14.3	57	21.1	21.6
Hispanic	76	34.2	12.8	12	25.0	2.4	88	32.6	8.0
Other	5	2.3	5.9	2	4.2	2.4	7	2.6	4.2
Total	222	100.0	12.8	48	100.0	2.9	270	100.0	8.0

Source: *Texas eHARS (unadjusted for reporting delay), 2011.*

The risk for the majority of AIDS cases reported each year in the TGA is male-to-male sexual contact (Figure 2). The percent of cases with male-to-male sexual contact as the risk has been steadily increasing in the TGA, reversing a significant decreasing trend throughout the 1990s. The proportion of AIDS cases reporting MSM risk in 2010 is similar to the proportion that reported MSM risk in 1992. One reason for this change may be the increase in risky sexual activities with anonymous or pseudonymous partners who meet over the Internet. In Austin and Travis County, male-to-male sexual activity was associated with Internet partners (source: Vest et al, *Sexually Transmitted Disease,* 2007).

Figure 2: Proportion of AIDS Cases by Exposure Category and Diagnosis Year, 1989-2010.

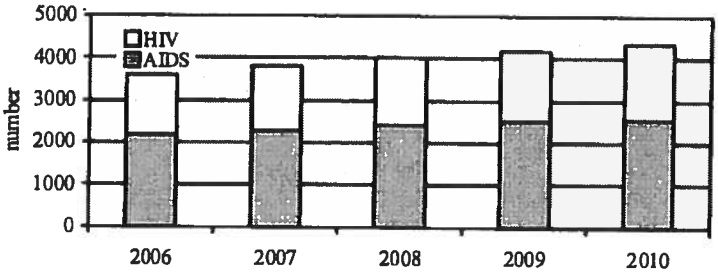


Source: *Texas eHARS (risk statistically redistributed), 2011.*

A total of 4,352 persons in the TGA were living with HIV infection as of 12/31/2010 (Attachment 3). Of those, a total of 1,791 persons were living with HIV (not AIDS). The steady increase in the prevalence of HIV infection since 2006 is illustrated below in Figure 3.

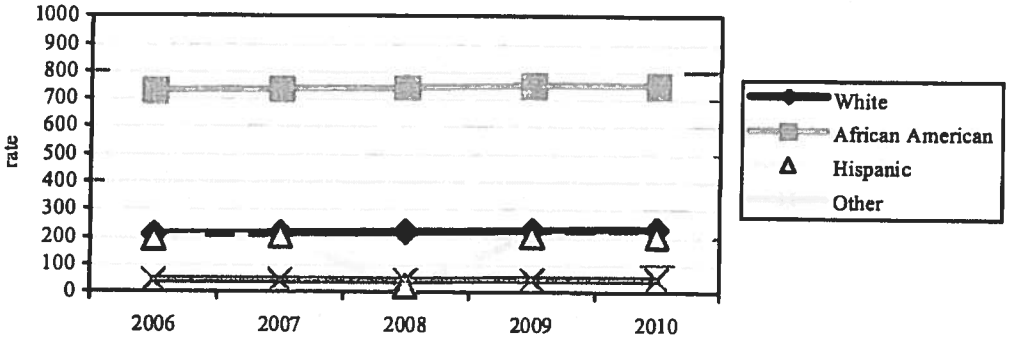
According to the Texas Department of State Health Services (DSHS) the prevalence of AIDS has increased 67.5% since 2000. Figure 4 indicates that highest prevalence rates of persons living with HIV infection (PLWH/A) are consistently among African Americans. Rates among African Americans living with HIV are approximately 3.3 times higher than other groups.

Figure 3: Number of Persons Living with HIV/AIDS, Austin TGA



Source: *Texas eHARS (unadjusted for reporting delays), 2011.*

Figure 4: Rate per 100,000 of Persons Living with HIV Infection by race/ethnicity, Austin TGA



Source: *Texas eHARS (unadjusted for reporting delays), 2011.*

Almost half of PLWH/A are White non-Hispanic (49.1%), and 84.4% are males. The highest burden of disease is among African Americans. The prevalence rate of HIV infection among African American males is 2.5 times higher than among White males, and the rate among African American females is eleven times higher than among White females (Table F).

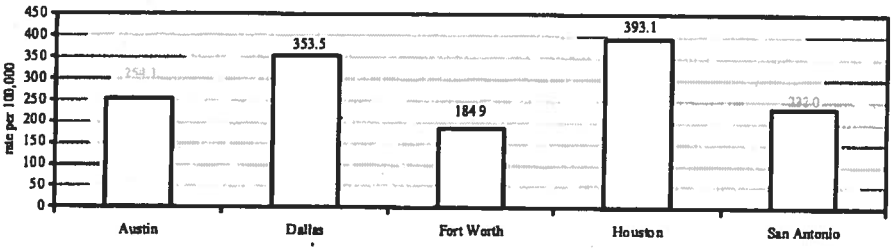
Table F: Prevalence rate per 100,000 of HIV infection in the Austin TGA, by race/ethnicity and sex, 2010.

	Males			Females			Total		
Race/ethnicity	**N**	**%**	**Rate**	**N**	**%**	**Rate**	**N**	**%**	**Rate**
White	1921	52.3	410.4	200	28.8	43.6	2121	49.1	228.9
African American	683	18.6	1023.0	327	48.8	486.3	1010	23.7	753.7
Hispanic	1018	27.7	333.9	143	20.6	54.7	1161	25.8	205.1
Other	49	1.3	113.0	11	1.5	25.9	60	1.4	69.9
Total	3671	100.0	415.7	681	100.0	82.1	4352	100.0	254.1

Source: *Texas eHARS (unadjusted for reporting delays), 2011.*

Austin TGA is not the most populous Texas EMA/TGA, but its burden of HIV infection is high. The prevalence of PLWH/A is the third highest in the state, higher than the more populous San Antonio and Fort Worth TGAs (Figure 5). Only the Austin, Houston, and Dallas EMAs/TGAs have HIV (not AIDS) prevalence rates in the triple digits (source: *Texas DSHS, 2011*).

Figure 5: Prevalence of Persons Living with HIV/AIDS, Texas EMAs/TGAs, 2010



Source: *Texas DSHS (unadjusted for reporting delays), 2011.*

Disproportionate Impact of HIV/AIDS on Populations in the TGA

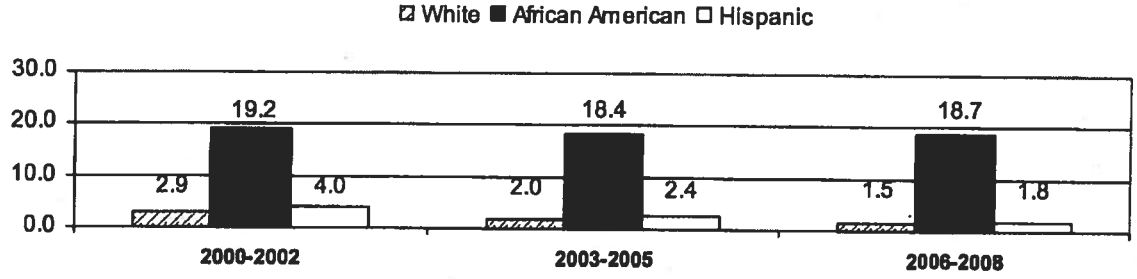
HIV/AIDS disproportionately impacts African Americans in the Austin TGA. The burden of disease is evident in disease incidence, prevalence, mortality, and by sex.

- In 2009-2010, African Americans accounted for only 7.8% of the TGA's population (source: *Texas State Data Center & Office of the State Demographer*), but 21% of new cases of both AIDS and HIV (Attachment 3 and Tables C and E).
- The 2009-2010 incidence rate of new AIDS cases is 3.5 times higher among African Americans than Whites and 3.0 times higher than Hispanics (Table E).
- The prevalence rate of HIV infection among African Americans is 3.3 times higher than Whites and 3.7 times higher than Hispanics (Table F).
- Figure 4 shows that race/ethnicity disparity consistently has remained wide since 2006.
- The 2006-2008 age-adjusted HIV mortality rate among African Americans is 12.5 times higher than among Whites (Figure 6).

In addition to these disparities by race/ethnicity, the greatest burden of HIV/AIDS remains among the MSM populations (see Attachment 3).

- In 2009-2010, the majority (68.4%) of new AIDS cases were among MSMs.
- Seven out of ten persons living with HIV infection have MSM as a risk factor.
- Among all men living with HIV infection, 7 in 10 (72.7%) have MSM as a risk factor.
- MSM is an increasingly more common risk factor among cases in the TGA (Figure 2).

Figure 6: Age-adjusted HIV mortality rate by race/ethnicity, Austin TGA.



Source: *Texas Department of State Health Services, 2011,* http://soupfin.tdh.state.tx.us.

Populations of PLWH in the TGA Underrepresented in Ryan White Funded System of HIV Primary Medical Care

Total unduplicated HIV patients seen by the Ryan White-funded HIV primary medical care provider in 2010 were compared to prevalence data in Attachment 3, to determine the level of representation by race/ethnicity, gender and risk. Data indicate primary medical care use by HIV (not AIDS) and AIDS patients is generally representative for gender and for all racial/ethnic groups (Table G). However, differences exist for primary risk factors. The proportion of MSMs in the Ryan White system is slightly lower than in the TGA.

Table G: Persons living with HIV infection in the TGA distribution compared to Ryan White Program medical care patient distribution.

Demographic Group	TGA %	Ryan White %
Race/Ethnicity		
White	49.1	37.5
African American	23.7	28.1
Hispanic	25.8	30.6
Other	1.4	2.4
Gender		
Male	84.4	80.0
Female	15.6	19.0
Transgender	--	1.0
Primary risk factor		
MSM	64.5	51.9
IDU	10.8	10.9
Heterosexual	15.6	12.8

Source: *Texas DSHS (eHARS July 2011 data unadjusted for reporting delays) and AIDS Regional Information and Evaluation System (ARIES), 2011.*

Estimated Level of Service Gaps among PLWH in the TGA

For a discussion of service gaps, refer to Assessment of Emerging Populations with Special Needs below on pages 10-17.

1) B. Impact of Co-morbidities on the Cost and Complexity of Providing Care

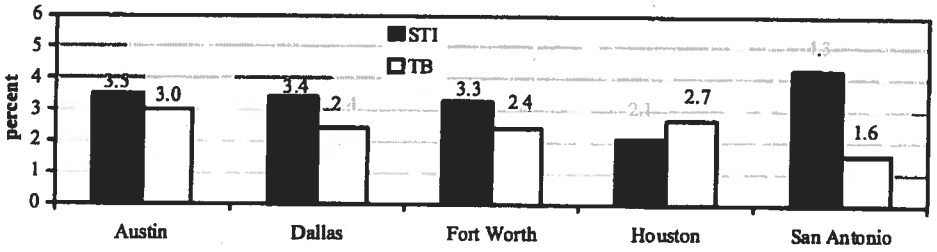
Data on Infectious Disease, Homelessness, Health Insurance, Poverty, Substance Abuse, and Mental Illness are shown in Attachment 4.

Number and rate (per 100,000) of selected infectious diseases

The high STI rates are evidence of a large sexually active population engaged in risky sexual behaviors. The Austin TGA's 2010 rate of Chlamydia (496.0 per 100,000) is the second highest among Texas EMAs/TGAs in 2010 (source: *Texas DSHS, 2011).* The higher rates may be due to the younger age of TGA residents and the large number of college and university students in Austin. The substantial disparities in infectious disease by race/ethnicity are also seen in STI

rates. Rates among African Americans and Hispanics are significantly higher than among White non-Hispanics. Syphilis transmission is increasing in the TGA. In 2000, the TGA saw 41 cases of early syphilis (source: *Texas DSHS, 2011).* By 2010, the number of new cases had increased to 246, or 205 times the 2000 number. Two facts make the increase particularly significant. First, since syphilis is relatively rare, STI transmission indicates frequent unprotected sexual activity with multiple sexual partners and other high-risk sexual practices through which HIV can be transmitted (source: *CDC, MMWR, 53, 2004*). Second, syphilis co-infection increases the risk of HIV transmission. Among Austin TGA syphilis cases reported in 2010, almost 25% were co-infected with HIV (source: *Texas STD*MIS, 2011*). Co-morbidity with TB is a greater issue in the Austin TGA. As Figure 7 indicates, the prevalence of TB co-infection, a risk factor for mortality and care complication, is higher than any other TGA in the state (source: *Texas DSHS, 2011*).

Figure 7: Prevalence of co-morbid disease, Texas TGAs, 2010



Source: *Texas DSHS STD*MIS and TB Program, 2011.*

Estimated number of homeless persons

The estimated number of homeless in the TGA is 8,518. Within the TGA there are 48 homeless individuals for every 10,000 persons. These numbers represent an undercount because they do not include homeless persons who do not seek services. Among PLWH/A, *Travis County Supplement to HIV/AIDS Surveillance (SHAS)* reports 5.1% with their living situation as "shelters or streets, " while participants identified housing-related services as the third-highest reported need (source: *2010 Austin TGA Comprehensive Needs Assessment*). Housing in the Austin TGA is expensive. The second quarter 2011 median home price is at least $42,800 higher than any of the other Texas EMAs/TGAs, and the median price increased 1.4% from 2010 to 2011. In contrast, the San Antonio TGA median home price only increased 0.4% during the same period (source: *Median Sales Price of Existing Single-Family Homes for Metropolitan Areas, National Association of Realtors, 2011*). The cost of services for homeless persons also has increased in the Austin TGA. From 2003 to 2006, the average cost per homeless client in the city of Austin has grown over 300% (source: *City of Austin FY 05-06 Performance Measures Volume 1, 2009).* Homeless individuals were among the most costly in the Ryan White HIV/AIDS Program system of care. The average homeless client costs 14.7% more than clients who were not homeless (source: *City of Austin ARIES, 2011*).

Number and percent of population (19-64 years old) without health insurance

Texas has the highest uninsured rate in the nation (source: *Income, Poverty, and Health Insurance Coverage in the United States: 2009, US Census Bureau*). Nearly 1 in 4 persons ages 19 to 64 do not have health insurance in the TGA. Among PLWH/A, estimates place the percent uninsured between 24.7% (source: *2010 Austin TGA Comprehensive Needs Assessment*) and

54.8% (source: *Travis County SHAS*). The percent of PLWH/A without documented public or private medical insurance seen by the Ryan White-funded HIV primary medical care provider was 65.9% in 2010 (source: *Austin ARIES, 2011*).

Number and percentage of persons living at or below 300 percent of the 2011 Federal Poverty Level, by race and ethnicity

53.1% of the Austin TGA lives at or below 300% of the 2011 Federal Poverty Level (FPL). A substantially larger percentage of African Americans (65.3%) live at or below 300% FPL level. Nearly three-fourths (74.2%) of Hispanics live at or below 300% FPL, which is significant because of the projected rapid growth of the Hispanic population in the TGA (source: *Texas State Data Center & Office of the State Demographer, 2011*). According to the *Travis County SHAS*, 42.6% of PLWH/A reported a household income of less than $29,000, approximately 300% FPL for a single person household. Also, 93.9% of clients seen by the Ryan White-funded HIV primary medical care provider in 2010 were at or below 300% FPL (source: *Austin ARIES, 2011*).

Number and prevalence of past year adult substance abuse among general population and persons living with HIV infection

The Austin TGA has the highest prevalence of illicit drug use of any Texas metropolitan area. One in five adults used an illicit drug in the past 12 months (Attachment 4). Following the high prevalence in the general population, a majority (75.3%) of the *Travis County Supplement to HIV/AIDS Surveillance (SHAS)* respondents used an illicit drug in the past year and 49.8% reported past year injection drug use.

Prevalence of adult mental illness among the general population and persons living with HIV infection

21% of adults in the TGA live with some mental illness (Attachment 4). The proportion is substantially higher among PLWH/A. According to the *Travis County SHAS*, 46.6% reported a mental illness diagnosis. Mental illness often complicates successful engagement in regular HIV medical care and treatment adherence. Within the Ryan White medical care system, 54.0% of those seeking mental health services were MSM (source: *City of Austin ARIES, 2011*). This is congruent with the *SHAS* which reported 50.5% of MSM respondents had a least one diagnosed mental illness.

Individuals who were formerly Federal, State or local prisoners and were released from custody of the penal system during the preceding 3 years

In the previous three years, a total of 12,620 Austin TGA residents have been released by the Texas Department of Criminal Justice (source: *Texas Department of Criminal Justice, 2011*). Among the incarcerated population in Texas, the estimated prevalence of HIV infection is 2.1% (source: *Texas Department of Criminal Justice, 2011*). For a description of impact on the service delivery system by individuals who were released from incarceration during the past three years, see the Assessment of Emerging Populations with Special Needs section on pages 10-17.

1) C. Impact of Part A Funding: Funding Mechanisms and Impact of Decline in Ryan White Formula Funding

(1) Report on Availability of Other Public Funding

Refer to Attachment 5 for amounts and percentages of total available public funding for HIV-related services in the specified eight categories for FY 2011, and anticipated public funding in the FY 2012 budget period. There was no decline in Ryan White Part A formula funding between FY 2010 and FY 2011.

(2) Coordination of Services and Funding Streams

Coordination with other Ryan White Programs

Most Ryan White programs in the Austin TGA are coordinated through the Austin/Travis County Health and Human Services Department (A/TCHHSD) which serves as the Administrative Agency for Ryan White Part A, including the Minority AIDS Initiative (MAI) Program, and Part C. There is no Ryan White Part D or Part F funding in the Austin TGA. Although the A/TCHHSD does not serve as Administrative Agency for Ryan White Part B, a Part B representative fills a designated slot on the Part A HIV Planning Council to assure optimal coordination with Part B and Texas HIV State Services funding. Moreover, Part A Administrative Agency staff meet quarterly with Part B Administrative Agency staff to coordinate efforts such as policy development and monitoring. Planning Council members also have participated in the development of the Texas Statewide Coordinated Statement of Need (SCSN).

Centralized coordination enables the HIV Planning Council to ensure that services provided by Part A, including MAI, do not duplicate those provided by other Ryan White funded grant programs. The Administrative Agency provided detailed information on funding from other Ryan White programs for consideration during the FY 2012 Part A and MAI priority setting and allocation processes. Prior to setting service priorities and allocating Part A funds, the Planning Council was able to identify gaps in services and allocate dollars strategically by examining all sources of funding for all eligible services.

Coordination with Other State and Federal Resources

In addition to serving as Administrative Agency for Ryan White Program funds, the A/TCHHSD receives Housing Opportunities for Persons with AIDS (HOPWA) and City of Austin funding for HIV services. To maximize coordination, the Austin HIV Planning Council provides input into development of the City of Austin Consolidated Plan for Housing Services, which includes funding for the HOPWA Program. The A/TCHHSD has oversight of major CDC Prevention Programs in the TGA, thereby facilitating close coordination of both HIV prevention and HIV care activities. Moreover, Part A grant subrecipients have received funding under a Centers for Disease Control (CDC) Initiative to provide counseling, testing and referral, prevention case management, and evidence-based interventions with high-risk and HIV positive persons. The HIV Planning Council carefully considered services duplication during its planning process.

The David Powell Community Health Center (DPCHC) for HIV primary medical care is an active Medicaid provider that has signed contracts with multiple Medicaid managed care companies. Texas Medicaid covers all clinical visits and provides some coverage for laboratory testing and prescription drugs for eligible clients. Since DPCHC does not allow patients to forgo needed drugs or procedures because of inability to pay, Ryan White Part B and Part C funds, as well as Part A, are combined for the purchase of pharmaceuticals. DPCHC bills for all covered services and receives an enhanced reimbursement rate due to its status as a Federally Qualified Health Center. For additional information on third party reimbursement mechanisms, see page 46.

Texas has a State Children's Health Insurance Program (CHIP), which generally covers children up to age 19 with family income less than 200 percent of poverty. In addition, the Texas Healthy Kids program covers children above 200 percent of poverty, ages 2 through 17, who have been uninsured for 90 days or more. HIV-infected children are referred to CHIP when eligible; with fewer than 40 pediatric cases of HIV/AIDS in the TGA, the impact of CHIP is not significant.

DPCHC screens individuals for Veterans Administration (VA) benefits as part of its intake process. However, since eligible veterans cannot be compelled to receive their medical treatment through the VA, medical case management staff can only educate patients about care available through the VA. If a veteran living with HIV prefers to receive care at DPCHC and has no other potential third-party payer, he/she is placed on the same sliding fee scale as any other uninsured patient. The regional VA estimates that approximately 40 veterans with HIV in the TGA are seen at its small outpatient clinic in Austin or, for specialty or inpatient care, at VA hospitals in nearby Temple or San Antonio, Texas.

A Part A subcontractor coordinates their Substance Abuse and Mental Health Services Administration (SAMHSA) funds with Ryan White Part A funds in order to deliver a comprehensive range of substance abuse services to persons with HIV in the TGA. SAMHSA-funded services include: HIV counseling and testing; early intervention; lab testing; street outreach; case management; prevention for HIV positive persons; and health education and risk reduction education. Part A complements these programs by funding other components of the substance abuse treatment spectrum.

1) D. Assessment of Emerging Populations with Special Needs

Six populations in the TGA have been selected for discussion of their special needs: injection drug users, substance users other than injection drug users, men of color who have sex with men, White men who have sex with men, African American women, and the recently released from jail/prison. Mental health issues were identified as significant barriers to care, with an estimated 47% of PLWH/A suffering from a mental illness. Therefore, mental health issues will be discussed within each special needs population.

Injection Drug Users (IDU)

There were 21,696 injection drug users in the Austin TGA in 2011, representing a significantly larger percentage in comparison to other areas (source: *Texas Commission on Drugs & Alcohol*). Of PLWH/A in the TGA, estimates place the percent of IDU between 6% (source: *2010 Austin*

TGA Comprehensive Needs Assessment) and 27% (source: *Travis County SHAS*). Men interviewed for the Travis County Supplement to HIV/AIDS Surveillance (SHAS) project outweighed the number of women in injection drug use (29% compared to 22%). Using the prevalence information presented in Attachment 3, it is estimated that 3.8% of the IDU population is HIV positive.

Unique Challenges

For HIV-positive IDUs, the greatest challenges for providers are risky behavior, the dual stigma of HIV and drug addiction, mental health problems, and adherence to treatment plans. The majority of all IDUs in the TGA share needles. More than 9 in 10 women, 7 in 10 Hispanics, and 8 in 10 African Americans who had ever used injection drugs had shared needles. Of people who shared needles, 43.5% shared with people they did not know, 14.1% with people they knew to be HIV positive, and 44.7% with people they knew to be men who have sex with men (source: *Travis County SHAS*). Drug abuse is also associated with disruption in daily living, making it difficult for PLWH/A to keep vital appointments or follow treatment regimens. Evidence of high unmet need can be seen when examining unmet need by exposure category (Table J, p. 19). In 2010, IDU had the highest percent of unmet need (29.6%). Within PLWH/A reporting exposure as IDU, males of all race/ethnicity groups had a higher percent of unmet need than females.

The 2005 HIV Needs Assessment identified barriers to care as: not wanting medical care; fear HIV status being discovered by others; cannot afford medical care; and actively using drugs/alcohol. Although not self-identified as a barrier, 75% of IDU respondents were experiencing a mental health problem. Depression and anxiety were the most common diagnoses.

Service Gaps

Significant service gaps reported in the 2010 Austin HIV Needs Assessment include psychosocial (non-medical) case management; AIDS drug assistance; transportation; and oral health services. With three-quarters identified as having a mental health problem, the IDU population has high need for mental health services. Gaps in oral health care, substance abuse services, mental health services, and medical transportation are common for several emerging populations including IDUs.

Estimated Costs for Delivering Services

Identifying HIV-positive IDUs and maintaining them in care requires extensive, long-term commitment of support, especially for substance abuse and mental health treatment. In the Ryan White funded system, the total costs for all services to IDUs in 2009 was $870,166; a decrease of 0.9% from the prior year (source: *City of Austin ARIES, 2010 & 2011*). Among IDUs, service costs were higher among men, Whites, and African Americans.

<u>Substance Users other than injection drug users</u>

The Austin TGA has the highest rates of drug use in the state of Texas (Table H). The overall rate of illicit drug use in the Austin TGA was twice that of any other Texas TGA/EMA, and drug use in the TGA is increasing (source: *2000 Texas Survey of Substance Use Among Adults;*

Substance abuse trends in Texas, June 2009). In 2008, 28,224 arrests in the TGA (or 28.0% of all arrests) were for drug and alcohol offenses (source: *Texas DSHS, 2009).*

Table H: Past-year prevalence of substance use and abuse among adults by Texas metropolitan area

Drug	Austin	Dallas	El Paso	Fort Worth	Houston	San Antonio	Texas
Any illicit drug	21.3	10.1	8.2	8.9	10.7	10.3	9.4
Marijuana	18.8	7.4	6.1	6.9	7.7	8.0	7.0
Cocaine/crack	4.6	2.4	1.1	1.2	1.8	5.5	2.0
Drug problems	10.7	5.2	4.8	5.0	6.1	7.6	5.2
Alcohol	76.9	70.7	67.8	63.4	71.8	69.4	65.7
Heavy alcohol	7.0	6.1	4.9	5.0	6.0	8.3	5.7
Alcohol problems	20.5	16.4	16.5	13.0	18.7	20.3	15.7

Source: *Texas DSHS, 2000.*

Substance Users represented 29.7% of respondents in the 2010 Austin TGA Comprehensive Needs Assessment. Overall, 79% of Travis County SHAS respondents reported ever using non-injection drugs. Substance abuse can lead to risky behavior. The Texas Department of State Health Services reported: "Of the Austin women tested for HIV in 2004, 2% of African Americans and 4% of Hispanics had used methamphetamine while having sex" (source: *Substance Abuse Trends in Texas, January 2006*).

Unique Challenges

The greatest challenges for care providers to HIV-positive Substance Users are risky behavior, the dual stigma of HIV and drug addiction, mental health problems, and adherence to treatment plans. Risky behavior is inherent when under the influence of drugs or alcohol. Twelve percent (12%) of 2005 Needs Assessment respondents reported commercial sex work as their mode of HIV transmission, and forty seven percent (47%) reported heterosexual sex as their mode of transmission. Approximately 29% of Travis County SHAS respondents had received money for sex.

Substance Users living with HIV face the dual stigma of HIV and substance abuse; they report feeling stigmatized by providers, other PLWH/A, in their neighborhoods and on the streets (source: *2005 Austin Area Comprehensive HIV Needs Assessment*). One respondent stated: "Substance abuse treatment that is available does not understand how to deal with people living with HIV." Moreover, in the 2005 HIV Needs Assessment, 70% of substance using respondents report mental health problems, with depression and anxiety being the most common. Substance abuse often is accompanied by disruptions to daily life, thereby significantly compromising treatment adherence. In Travis and Williamson Counties, 25.4% of homeless persons were substance abusers (source: *Austin/Travis County Continuum of Care Application, 2008*).

The 2005 HIV Needs Assessment identified barriers to care as: fear HIV status being discovered by others; cannot afford medical care; fear one's children discovering HIV status; and believe medical care not necessary. Mental health issues may be additional barriers, given the high rate of respondents with this co-morbidity.

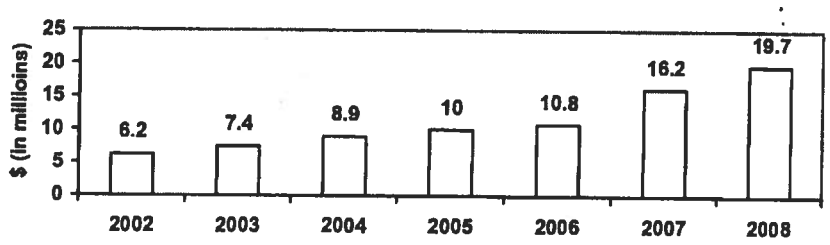
Service Gaps

The 2010 HIV Needs Assessment identified service gaps as: psychosocial (non-medical) case management, AIDS drug assistance, outpatient/ambulatory medical care, and oral health services. Housing Service providers in the 2005 HIV Needs Assessment stressed the inadequate capacity of all services, especially mental health and substance abuse treatment. Additionally, treatment adherence counseling is important in helping PLWH/A who are experiencing chaotic lifestyles.

Estimated Costs for Delivering Services

Like IDUs, Substance Users require extensive, long-term commitment of support to stay in care. The high cost is demonstrated by hospitalization data that show, in 2008, substance use-related hospitalization costs for TGA residents exceeded $19 million (Figure 8). Overall, the inpatient hospital costs in the TGA for substance use related admission have increased by 218% since 2002, with an increase of 22% since 2007. These figures do not account for the added cost of emergency room and private physician visits, or hospital admission where drug use was noted but not the primary reason for admission.

Figure 8: Total Inpatient Hospitalization Costs (in millions) from substance use related admission, Austin TGA



Source: *Texas Hospital Inpatient Discharge Public Use Data File, 2002-2008. Texas DSHS, Center for Health Statistics-THCIC, Austin, Texas, 2011 & Agency for Healthcare Research & Quality CCS-MHSA software.*

Men of color who have sex with men

Of the 213 men of color diagnosed with HIV in 2009-2010, 79.4% had a risk factor of MSM, including MSM and IDU (source: *Texas eHARS, 2011*). Among men of color living with HIV, MSM (including MSM and IDU) was the most common risk factor (78.7%). MSM (including MSM and IDU) was the most common risk factor among men of color for African Americans (67.8%), Hispanics (85.7%), and Asian and Pacific Islanders (86.8%). The average age of men of color MSMs at age of HIV diagnosis was 32.9 years, while the average age of White-non Hispanic MSMs at HIV diagnosis was 35.3 years. Although representing a small percent of all PLWH/A, the majority of male youths (13-24 years old) reported with HIV during this period were men of color (65.8%) (Source: *Texas eHARS, 2011*).

Unique Challenges

The greatest challenges for providers of services to HIV-positive men of color MSMs are stigma, lack of HIV education, and risky behavior. Men of color MSMs face the multiple stigmas of being MSM, HIV-positive, and racial/ethnic minority. This translates into a higher number of men of color MSMs with unmet need in the TGA; in 2010, 691 MSM had unmet need (source: *Texas DSHS, 2011*). Stigma extends beyond health care providers and the larger society to their own communities, where many men of color MSMs do not identify as gay, making them a 'hidden population'. TGA provider data reported that minorities had a lower level of knowledge about HIV/AIDS, found out about their HIV status at a later stage of disease, or knew their status but chose not to use services until a late stage of disease. These factors increase the cost and complexity of providing services to clients. The 2005 HIV Needs Assessment identified barriers to care as: cannot afford medical care, fear HIV status being discovered by others, and fear of their children discovering HIV status.

Service Gaps

The 2010 HIV Needs Assessment identified service gaps as: psychosocial (non-medical) case management, AIDS drug assistance, outpatient/ambulatory medical care, and oral health services. According to ARIES data, African American and Hispanic men had more service visits than White men. African American men averaged 65 visits and Hispanic men 58 visits, compared to White men who averaged 46 visits.

Estimated Costs for Delivering Services

Identifying and bringing into care men of color MSMs requires additional focus on unmet need as well as outreach and adherence services. City of Austin Disease Intervention Specialists performing HIV case investigation report men of color are more likely to deny male to male sexual contact. For 2010, ARIES data from all funding sources and all providers indicated 669 African American and Hispanic MSMs accessed services for a total cost of $1,926,579 (source: *City of Austin ARIES, 2011*). The average expenditures for African American and Hispanic MSMs were higher than for White non-Hispanics.

<u>White men who have sex with men</u>

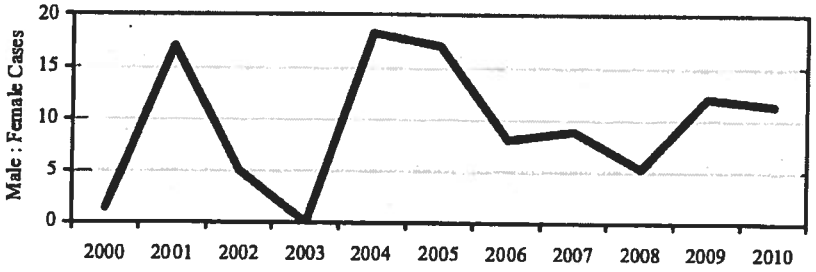
White men who have sex with men comprised 36.7% of all PLWH/A in the TGA. When White MSMs who are injection drug users are included, the percentage increases to 41.1%. In 2009-2010, 34.4% of all newly diagnosed AIDS cases were White MSM. (Source: *Texas eHARS, 2011*). HIV-positive White MSMs also have the largest number of persons with unmet need among all race/ethnicity groups in the TGA (source: *Texas DSHS, 2011*). The total size of the MSM population is not known, but an estimated 8.1% of the male TGA population is MSM (source: *Holmberg SD, American Journal of Public Health 36(5), 1996*).

Unique Challenges

White MSMs continue to constitute the largest number of PLWH/A in the TGA. Risky sexual behavior and substance abuse present significant challenges for providers of care to HIV-positive White MSMs. Figure 9 demonstrates the increased risky sexual behavior among White MSMs in the area. In 2000, there was only one case of early syphilis among men for each female. In 2010, for every one white female case of early syphilis, there were 11.3 male cases. From 2004 to 2007, the ratio of white male to white female early syphilis cases was much wider, an

indication of transmission primarily in males (source: *Texas STD*MIS, 2011).* The present decrease in the ratio may indicate that whites of both sexes are engaging in riskier sexual behavior, exposing more women to syphilis. The larger number of early syphilis cases reported in women may also be due to efforts to increase active surveillance. The 2005 HIV Needs Assessment found that 22% of White MSM had a history of IDU and 59% reported substance abuse, thereby presenting another challenge.

Figure 9: Ratio of White Male to White Female Early Syphilis Cases, Travis County.



Source: *Texas DSHS, STD*MIS, 2011*

Service Gaps

Significant service gaps found in the 2010 HIV Needs Assessment include: oral health services, medical case management, outpatient/ambulatory medical care, and AIDS drug assistance. In addition to these self-reported needs, providers and surveys indicate that significant numbers of White MSM need mental health, substance abuse, and health education/risk reduction services.

Estimated Costs for Delivering Services

Within the Ryan White funded system of care, more dollars are spent on White MSMs than on any other risk group/ethnicity combination (source: *City of Austin ARIES, 2011*). White MSMs accounted for 50.3% of funding for services within this system, for a total cost of $2,047,703.

African American Women

In 2011, 54.6% of all women in the TGA were White, 32.1% were Hispanic, 8.1% African American, and 5.2% other races/ethnicities (source: *Texas State Data Center and Office of the State Demographer, 2011).* Although among the smallest race/ethnic groups in the TGA, just under half (48.8%) of all females living with HIV/AIDS were African American (source: *Texas eHARS, 2011*). This disparity is also evident among young women. Among women living with HIV/AIDS who were 13 to 24 years old at time of diagnosis, the majority (59.3%) were African American (source: *Texas eHARS, 2011*). Heterosexual contact (68.4%) and injection drug use (28.3%) are the primary modes of transmission among African American women (source: *Texas eHARS, 2011*).

Unique Challenges

Several factors complicate access to care for African American women. The percent of African American women living in poverty (24.5%) was 2.4 times that of White non-Hispanic women (10.2%) in the Austin TGA (source: *US Census Bureau 2010 American Community Survey).* Additional challenges include care for children, responsibility to family, and domestic violence.

According to the 2005 HIV Needs Assessment, 23% of out-of-care women reported not seeking care out of fear of being abused by a partner. African American women also reported a fear of revealing their HIV status to the community and family. As previously noted, intravenous drug use is the second major mode of transmission, highlighting substance abuse as a significant challenge. These issues may contribute to African American women living with HIV/AIDS having a higher number with unmet need than other race/ethnicity groups in the TGA in 2010 (source: *Texas DSHS, 2011*).

Service Gaps

According to the 2005 HIV Needs Assessment, a higher percent (36%) of African American women were out-of-care than among women overall. Service gaps reported in the 2010 HIV Needs Assessment included: oral health services, mental health services, transportation, utility assistance, and AIDS drug assistance. Comments from focus group participants also suggested that support groups facilitated by a mental health professional would be beneficial.

Estimated Costs for Delivering Services

Within the Ryan White funded system of providers, 259 African American, 132 Hispanic and 17 women of other races/ethnicities sought care for services. The average cost per African American female client was $3,591, which was the highest average cost for any gender and race-ethnicity combination. The average cost for Hispanic women was $3,565, slightly lower than the cost for African American women (source: *City of Austin ARIES, 2011*).

Incarcerated / Recently Released

The incarcerated and the recently released from jail/prison are populations disproportionately affected by HIV/AIDS. The 2009 estimated prevalence of HIV/AIDS in the overall Texas incarcerated population was 2.1% (source: *Texas Department of Criminal Justice, 2011*). The prevalence of HIV in the incarcerated population is substantially higher than the overall HIV prevalence in the Austin TGA. It is estimated that 5% of the incarcerated HIV positive population reside in Travis County (source: *Access to Correctional Health Care, American Civil Liberties Union of Texas, 2009*). The number of Austin TGA residents incarcerated in 2010 was 7,875. The distribution of incarcerated residents by race/ethnicity and sex is presented below in Table I. The majority of incarcerated Austin TGA residents were male. Rates of incarceration per population indicate a higher prevalence among African Americans.

Table I: Currently incarcerated and recently released Austin TGA residents by sex and race/ethnicity, 2010.

	Incarcerated			Recently Released		
	N	**%**	**Prevalence**	**N**	**%**	**Prevalence**
White	2,459	31.2	0.3	1,229	30.7	0.1
African American	2,426	30.8	1.8	1,317	32.9	1.0
Hispanic	2,950	37.5	0.5	1,425	35.7	0.2
Other	40	0.5	0.0	26	0.7	0.0
Male	7,327	93.0	0.8	3,520	88.1	0.4
Female	548	7.0	0.1	477	11.9	0.1
Total	**7,875**	**100**	0.4	**3,997**	**100.0**	**0.2**

Source: *Texas Department of Criminal Justice, 2011.*

The recently released represent a fast-growing and sizable population in need of services and HIV care. Table I describes characteristics of the recently released in the TGA. A total of 3,997 Austin TGA incarcerated were released into the community in 2010, a slight decrease of 4.7% from the previous year. The vast majority of individuals released in the TGA (66.7%) were Travis County residents. Most of the recently released were men (88.1%) and persons of color (69.3%). During the past three years, the total number of individuals released from incarceration in the TGA was 12,620. This population's HIV prevalence results in a disproportionate burden of recently released PLWH/A seeking services in the TGA, many with co-morbidities such as substance abuse and mental illness which complicate their care. The recently released also require effective transition programs to help them avoid re-incarceration and continue the HIV treatment received while incarcerated.

Unique Challenges
Numerous challenges exist in managing and preventing HIV/AIDS among the recently released. Substance abuse presents a challenge in getting these individuals into care, with 52% of out-of-care recently released reporting alcohol and drug use as their most frequently identified reason for being out of care. The recently released have lower levels of educational attainment when compared to the population as a whole. Among recently released, 38% have not graduated from high school (source: *2005 Austin Area Comprehensive HIV Needs Assessment*).

Service Gaps
According to the 2010 HIV Needs Assessment, the recently released population ranked transportation first among their most frequently identified service gaps. There is a significant gap for basic needs services as well. Other service gaps included: utility assistance, housing, food bank, and oral health services. Focus group participants indicated that services are needed to help the recently released navigate housing barriers and criminal justice obstacles. Furthermore, 89% of recently released participants were not provided with transitional services to assist them in accessing HIV medical and social services, obtaining prescriptions, and entering into case management (source: *2010 Austin TGA Comprehensive Needs Assessment*).

Estimated Costs for Delivering Services
In the Ryan White funded system, the total expenditure on those who have been recently released increased significantly since 2008. In 2010, more than $304,390 was spent on services for persons who were identified as in prison in the previous three years, representing a 16% increase from 2008 (source: *City of Austin ARIES, 2011*). This amount is an underestimate, since all providers do not uniformly or systematically collect this information.

1) E. Unique Service Delivery Challenges

Co-morbidities, high poverty, and low rates of health insurance coverage increase the challenge of providing care to PLWH/A in the TGA in three main ways. First, these factors tend to complicate the prevention and management of HIV infection and AIDS. Second, they are associated with inadequate information about the disease, its prevention and treatment, availability of services, and reduced ability to navigate the care system. Third, historically underserved and hard-to-reach clients are disenfranchised from health and other social service

systems in general. Moreover, they may not access care regularly or adhere to treatments because of impaired judgment from substance abuse or mental illness. The high prevalence of injection drug and other substance abuse in the TGA not only complicates the management of HIV/AIDS but it also puts the user at risk for other infections. Homelessness reduces the ability of the care system to reach patients and often leads to poor adherence to treatment regimens. These factors also are associated with diagnosis at a later stage of the disease, and multiple social problems.

The growing numbers of PLWH/A and the cost of antiretroviral therapies also are affecting the TGA's ability to provide services. The need for expensive genotypic and phenotypic assay and other laboratory testing imposes an additional cost burden on the primary medical care system. Early intervention is now more critical because of effective treatment options; however, those most in need of care often are least willing or able to access and remain in primary medical care. Other factors that complicate service needs and impair effective service delivery in the TGA include changes in managed care, effects of the economic downturn, and cutbacks in basic social services previously funded by the Ryan White Program.
Additional service delivery challenges unique to the Austin TGA are summarized below:

- Many PLWH/A move to Austin to seek care, with nearly 1 in 4 newly reported cases of HIV and AIDS in the TGA already documented as cases in other jurisdictions.
- Continuity of care remains a critical problem, with clients experiencing barriers in accessing specialty care within the local indigent health care system. More subspecialty care providers are reluctant to accept Medicaid or Medicare clients.
- Increasingly, patients diagnosed with AIDS while in the hospital are started on antiretroviral (ARV) medications without regard to payment sources. Upon discharge, these patients come to David Powell Community Health Center (DPCHC) needing to continue treatment but with no payment source.
- Nearly 1 in 4 persons ages 19 to 64 do not have health insurance in the TGA; more than half (54.4%) lives at or below 300% of the 2011 Federal Poverty Level (FPL).
- Of 254 Texas counties, Travis County is the fourth most common county of residence for the newly released HIV positive incarcerated population. Since clients leave the prison system with no more than a ten-day supply of ARV medications, the DPCHC incurs significant pharmaceutical cost.
- The TGA has the highest prevalence of illicit drug use of any Texas metropolitan area.
- The DPCHC reports that more than 40% of its HIV patients have injection drug use and/or mental illness co-morbidity.
- The high rates of STIs, and particularly Chlamydia which is the second highest rate among the other Texas EMAs/TGAs, are evidence of high levels of risky sexual behavior in the TGA, especially among White MSMs.
- In 2009-2010, the rate of newly diagnosed HIV cases among African Americans in the TGA was 3.6 times higher than the rate among Whites, and 3.0 times higher than the rate among Hispanics.

1) F. Impact of Decline in Ryan White Formula Funding

For FY 2011, the Austin TGA did not experience a decline in Ryan White Part A formula funding.

1) G. Unmet Need

The Unmet Need Framework is Attachment 6.
The 2008-2010 unmet need estimate is shown in Table J below.

Table J: Number and Percent of Living with HIV/AIDS with Unmet Need for Medical Care, 2008-2010.

	2008		2009		2010	
	No.	%	No.	%	No.	%
Disease Status						
HIV	539	33.4	604	36.2	533	29.8
AIDS	555	23.1	578	23	562	21.9
Sex						
Female	157	24.9	166	25.5	154	22.6
Male	937	27.7	1,016	28.8	941	25.6
Race/Ethnicity						
White	544	27.7	586	28.8	528	24.9
African American	260	27.6	270	27.6	270	26.7
Hispanic	276	26.3	306	27.7	283	24.4
Other	9	26.5	15	40.5	9	22.5
Unknown	5	21.7	5	25	5	25.0
Age						
< 2	.	.	.	.	.	.
2-12	3	25.0	3	27.3	3	33.3
13-24	58	36.9	51	34.2	45	27.6
25-34	216	32.4	245	35.7	226	32.3
35-44	361	26.1	385	28.4	340	25.8
45-54	339	25.5	359	25.5	333	22.0
55+	117	25.0	139	24.6	148	22.8
Category						
MSM	689	27.1	763	28.6	691	24.6
IDU	145	31.3	143	30.9	138	29.6
MSM / IDU	92	26.4	83	23.6	91	25.6
Heterosexual	160	26.1	187	28.8	169	25.0
Pediatric	7	21.2	6	17.1	4	11.4
Adult Other	-	0.0	-	0	1	16.7
Total	1,094	27.3	1,182	28.3	1,095	25.2

Source: *Texas DSHS, as of 12/31/2010.* Note: Numbers may not sum to totals due to rounding error and risk statistically redistributed.

Unmet Need Estimate

The Texas Department of State Health Services (DSHS) estimates the number of PLWH/A with unmet need at 1,095 persons, or 25.2% of the entire PLWH/A population. Unmet need for medical care is identified using the HRSA definition: a person living with HIV has unmet need for medical care if there is no evidence of either a CD4 count, a viral load test, or antiretroviral therapy during the 12 months of interest. If there is evidence of any one of these three events being present, the person is considered to have their medical needs met. DSHS supplies these data to Texas EMAs and TGAs, since local health departments do not have the capacity to perform the analysis.

Estimation Methods

DSHS HIV/STD Epidemiology and Surveillance Branch (DSHS, Part B grantee), Texas Part A Administrative Agencies and HIV Planning Council staffs collaboratively developed the specific methodology used to determine the quantitative estimate of unmet need. The unmet need estimate matched individuals from six datasets representing different funding streams:

- Electronic HIV/AIDS Reporting System (eHARS). This is the data source that is used as the universe of HIV/AIDS cases for estimating unmet need, retention in care for PLWH, linkage to care for newly diagnosed individuals, and continuity of care for outpatient/ambulatory medical care visits, CD4 labs, and viral load labs.
- Texas AIDS Drug Assistance Program (ADAP) or State Pharmacy Assistance Program (SPAP). If ADAP/SPAP provided antiretroviral (ARV) medications for a client, then that person was considered to have met medical need for the year in which the medication was provided. Name based matching was performed to determine persons with a met medical need during 2010.
- Electronic Lab Reporting (ELR). The largest providers of laboratory services throughout the state report CD4 and viral load labs to DSHS. Name based matching of these reports was used to determine if individuals received a CD4 count or viral load test during 2010. Note that most paper-based labs were not available at the time these measures were developed and are not reflected in the estimates.
- AIDS Regional Information and Evaluation System (ARIES). Services provided to Ryan White eligible clients by funded service providers are reported in ARIES. If a client received a viral load, CD4 count, laboratory service, ARV medication, or an outpatient/ambulatory visit medical care during 2010, the client was reported as having a met medical need during that year. When available, name based matching was used to determine persons with a met medical need during 2010. When client names were not available, matching was based on a unique record number generated in ARIES and eHARS.
- Medicaid/ Children's Health Insurance Program (CHIP). If a client received a viral load, CD4 count, laboratory service, ARV medication, or an outpatient/ambulatory medical visit through Medicaid/CHIP during 2010, the client was reported as having a met medical need during that year. Name based matching was performed to determine persons with a met medical need during 2010. Note that at the time of the project, the fourth quarter of 2010 Medicaid/CHIP data were not available for release at the time these estimates were developed and are not reflected in the estimates.
- Private Insurers. For this analysis, a few of the largest private providers in Texas extracted relevant procedures (CD4 counts, viral load measurements, ARV, or an outpatient medical

visit) from their claims systems. Matching was based on available data elements such as first and third initial of first and last name, date of birth, and sex.

Limitations

Estimates are limited by several factors: 1) They do not include all the HIV-related care provided by the VA, Medicare, and all private providers in the state. 2) Matches conducted between eHARS and some of the cases in ARIES and between eHARS and private payer data were based on a unique identifier or limited data elements rather than client name; this may underestimate the true number of clients with met need from these data sources. 3) There are persons reported in eHARS who have since moved out of the state (out-migrated cases) and, since there is not a systematic way of identifying and removing these out-migrated cases, they remain in the denominator and inflate our unmet need estimate. DSHS did not exclude Texas Department of Criminal Justice (TDCJ) cases when estimating unmet need for 2010, and did not exclude TDCJ cases when recalculating unmet need estimates for previous years. They were also not excluded in the linkage to care analysis. When TDCJ cases are excluded, the statewide unmet need estimates increased by approximately one or two percentage points. While including TDCJ cases in this year's unmet need analysis did not impact overall estimates, it is evident that DSHS is not receiving all medical service data for cases diagnosed in TDCJ. In addition, University of Texas Medical Branch paper labs received by DSHS were not available at the time these measures were developed and are not reflected in the estimates.

Caution is warranted when interpreting the apparent differences in unmet need from previous estimates. Fluctuations in unmet need across different years could be a result of changes in data reporting or matching returns, identification of duplicates, a cleaner Texas eHARS file and greater data availability, and not necessarily due to improvements in care. In 2009, DSHS identified that a de-duplication of records within Texas and with other states, and a major death update (where eHARS records were matched with vital statistics) have resulted in updates to a substantial number of cases, making for a more accurate estimate of unmet need. In addition, the 2010 estimates also reflect a recent major death update and an increase in lab data reporting which is the result of a mandate in Texas.

Assessment of Unmet Need Trends, 2008-2010

- Although the number of PLWH/A increased in Texas over the 2007-2010 period, unmet need decreased by approximately five percentage points from 38% in 2007 to 33% in 2010, which resulted in approximately 21,000 to 23,000 PLWH/A not in care each year. This decrease in unmet need occurred mostly between 2009 and 2010, and is largely driven by the increase in lab reports available for estimating met need. Approximately 55% of PLWH with met need reported having at least one CD4 or viral load lab in 2010. This is a significant increase from 2007 when only 42% of PLWH with met need reported having one CD4 or viral load lab.
- In 2010, 1,095 PLWH/A in Austin TGA had unmet need, or 25%, representing a 5.0% decrease from 2007.
- The majority of PLWH/A with unmet need from 2008-2010 are males. The number of male PLWH/A decreased from 987 in 2007 to 941 in 2010, or a 4.7% decrease.
- The percent with unmet need from 2008-2010 did not vary greatly by race/ethnicity, but each group experienced a decrease over the three years. Similar proportions of White (24.9%), African American (26.7%), and Hispanic (24.4%) PLWH/A had unmet need in 2010.

- The exposure category with the highest percentage of unmet need from 2008-2010 was injection drug users (29.6% in 2010). The number of IDU PLWH/A with unmet need decreased 4.6% from 2008 to 2010. IDU males of all races/ethnicities had higher numbers of persons with unmet need than IDU females for 2008-2010.
- The most common age with unmet need is 2-12 years old (33.3%). This represents a large subpopulation who may seek services over a longer period of time than older age groups.
- The proportion of PLWH (not AIDS) not receiving medical care is greater than the proportion of PLWA with unmet need for 2008-2010. The number of PLWH and PLWA remained steady from 2008 to 2010. In 2010, 29.8% of PLWH had unmet need, compared to 21.9% of PLWA. This difference may be attributable in part to the large proportion of AIDS cases that meet the case criteria for AIDS as a result of CD4 testing, which also is an indicator of met need.
- Whites exhibit smaller differentials when comparing HIV and AIDS unmet need proportions (25% vs. 24% in 2010); the proportion with unmet need among African American and Hispanic HIV cases is much higher than it is for AIDS cases in the TGA.
- The twenty most common ZIP codes with unmet need were identified based on residence at the time of their most recent diagnosis. All but two ZIP codes with the most individuals with unmet need were within Travis County; the percent of PLWH/A with unmet need was greater than 25% in some of these ZIP codes.

The HIV Needs Assessment evaluated unmet need, service gaps, and barriers to care for HIV-positive persons not in care. Information on specific populations was presented above, beginning on p. 10. The needs, gaps and barriers for the entire out-of-care population are summarized in Table K, below. Service needs include basic assistance and assistance with health insurance. The most important gap in services for the out-of-care population was health insurance. Barriers to getting into care took several different forms: fear of having HIV status revealed; perceptions care was not necessary; and other factors such as substance abuse and financial concerns.

Table K: Leading service need, gaps and barriers for the out-of-care population, Austin TGA.

Service Need	Gap	Barrier
Psychosocial case management	Health insurance	Fear of disclosure of HIV status
Primary medical care	Emergency financial assistance	Don't want medical care
Oral Health care	Housing assistance	Not currently sick
HIV medication assistance	Oral health	Financial reasons
Mental health services	Food bank	Current substance use

Source: *2005 Austin Area Comprehensive HIV Needs Assessment and 2010 Austin TGA Comprehensive Needs Assessment*

For information on how results of the Unmet Need assessment have been used in planning and decision-making about priorities, resource allocations, and the system of care, refer to Section 5, Planning and Resource Allocation on p. 52.

2) Early Identification of Individuals with HIV/AIDS (EIIHA)

2) A. AUSTIN TGA EIIHA STRATEGY TO IDENTIFY INDIVIDUALS WHO ARE UNAWARE OF THEIR HIV STATUS

The Austin Transitional Grant Area's (TGA) overall strategy is to collaborate with existing organizations performing EIIHA activities to develop a coordinated and seamless system which identifies, informs, refers, and links high-risk unaware HIV positive persons to medical care. Successful development and implementation of this system involves collaboration between HIV prevention and care service providers. The Austin Area HIV Planning Council (AAHPC) will serve as the lead organization in developing this coordinated system through the establishment of an EIIHA collaborative. The collaborative will be composed of representatives from the major EIIHA service providers in the TGA. In the Austin TGA, HIV prevention and testing services have not historically been well coordinated with Ryan White care services due to, among other things, separate and exclusive funding requirements. Thus, the proposed strategy represents the area's initial effort to engage in active and deliberate coordination activities that will result in a more efficient system.

(1) (a) Goals to be achieved and how each goal is consistent with the National HIV/AIDS Strategy

The TGA has adopted goals from the National HIV/AIDS Strategy which will ensure that the TGA's overall strategy is achieved and ensure that the goals are consistent with the National Strategy. The specific goals are listed below.

- *Increase the number of individuals aware of their HIV status*
- *Reduce HIV Related Health Disparities*
- *Increase the number of HIV positive individuals who are in care*
- *Increase Access to Care and Improving Health Outcomes for People Living with HIV*
- *Reduce New HIV Infections*

How each goal is consistent with making individuals who are unaware of their HIV status aware of their status

All of the goals are consistent with making individuals who are unaware of their HIV status aware of their status in the following manner. The goal of increasing the number of individuals aware of their HIV status is apparent and will be achieved through activities addressed in the next three goals. The goal of reducing HIV-related health disparities cannot be achieved until factors which cause TGA residents to avoid learning their HIV status are addressed. Recent studies in the TGA indicate that stigma associated with HIV remains high and fear of discrimination may be causing some unaware racial and ethnic groups from testing. Additional studies reveal that these heavily impacted populations may not view HIV as a primary concern. They are experiencing problems with reentry into the community following incarceration, unemployment, lack of housing, and other pressing socioeconomic issues. The goals of increasing the number of HIV positive individuals who are in medical care and increasing access to care will result in improved health outcomes if they get into care as early as possible after being infected. The TGA's strategy to collaborate and coordinate with EIIHA service providers will result in a seamless system to immediately link people to the area's existing continuum of care when they are diagnosed with HIV. Reducing new HIV infections in the TGA can be achieved by strategically concentrating area resources in communities at high risk for HIV

infections. Additionally, by increasing the number of individuals in care, the risk of transmitting the virus to others is reduced. In order to address these issues, the TGA will develop community-level collaborations that integrate HIV prevention and care with its more comprehensive responses to social service needs.

(1) (b) How this strategy coordinates with other programs/facilities and community efforts
The overall strategy of collaborating with existing EIIHA service providers to develop a better coordinated system will enhance the following community efforts: The following initiatives will be coordinated with the TGA's overall EIIHA strategy in 2012.

Social Marketing Campaign
In 2009, SUMA/Orchard Social Marketing, Inc. (SOSM) conducted research to develop a social marketing campaign targeted toward African Americans and young MSM in the Austin/Travis County service area. This study, funded by the City of Austin identified gaps and opportunities to provide information and outreach regarding HIV prevention, testing and care services for the targeted populations. Nine focus groups were conducted with a total of 96 respondents including gatekeepers and healthcare professions, HIV outreach workers, African American men, African American Women, African American MSM, and MSM of all races. Additionally, 19 in-depth one-on-one interviews were conducted with HIV service provider organizations, other stakeholders, and DIS.

As a result of this formative research, the following products/programs have been developed for early intervention use in FY 2010: seventeen-minute HIV video: *Living with HIV is Not Dying of AIDS*; website: www.AustinHIV.com which includes testing and referral information; four-color tri-fold brochure: *Living with HIV is Not Dying of AIDS*; four-color desk kiosk: *Trained as an HIV Care Messenger*; and a three-hour HIV Continuing Education Units (CEU) program for social service agency staff, including those with professional licensure, on HIV resources, testing issues, and referral to care. Other social marketing campaign activities for FY 2011 will focus on getting African Americans and MSMs who do not know they are HIV positive tested and linked to medical care and health-related support services. Additional research will be conducted with Spanish-dominant populations in the Austin TGA, in order to develop strategies to better reach them with HIV testing and care messages.

Test Austin Initiative
An HIV testing campaign has been developed in collaboration with the A/TCHHSD Communicable Disease Unit (CDU). *Test Austin* is an initiative to test as many individuals as possible in a focused period of time. For the pilot event, SOSM was employed to assist with the planning and media campaign. The campaign was highly publicized on radio, television, local newspapers and media outlets with a race/ethnic minority focus. Twenty dollar gift card incentives were used to entice individuals to take advantage of the services. The highlight of the campaign was a walk-in testing event at the RBJ Health Center conducted on December 21 with the support of Sexually Transmitted Infection (STI) Clinic staff. During the one-day *Test Austin* event, 152 individuals tested for HIV and STIs. One new and two previous HIV positives were identified and interviewed by DIS staff on site. During the time of the *Test Austin* campaign, from December 14 to December 31, excluding the December 21 event, 91 more individuals were tested for HIV. From these, two new HIV positives were identified. All have been notified and are being referred for care. This highly successful program will be replicated during FY 2011.

Opt-Out Testing

In FY 2010, the local network of FQHCs, CommUnityCare, began implementing CDC-recommended opt-out HIV testing, a project funded by the Travis County Healthcare District (Central Health). Using demographic and surveillance data and information from HIV testing programs, three clinics were identified as the pilot sites. These clinics had a high percentage of Hispanic and African American patients, two populations that are disproportionately HIV-infected in the Austin TGA. CommUnityCare has over 50,000 patients; nearly 2,000 of those patients are at the David Powell Community Health Center and already have a diagnosis of HIV or AIDS. Of the remaining patients, 30,000 are between the ages of 18 and 64. In 2011, CommUnityCare was awarded a grant from the Texas Department of State Health Services (DSHS) to expand its Op-Out testing initiative to all clinics sites. This screening approach could identify a significant number of persons unaware of their HIV status. In FY 2011, the A/TCHHSD's STI Clinic will continue its successful HIV opt-out testing program. In the most recent six month period for which data are available, 5,171 persons were tested for STIs at the clinic. Of those, 5,091 consented to an HIV test.

(1) (c) How EIIHA activities and strategies will be incorporated into the program's Requests for Proposals (RFP's)

For FY 2012, Planning Council allocated funds to the Early Intervention Services (EIS) category in order to support EIIHA activities. Following review of the 2011 EIIHA Plan, the Planning Council developed directives that defined the scope of work for EIS and focused on using outreach services to identify unaware target populations listed in the EIIHA Matrix. Program activities will be designed to meet specific needs of each target group, in order to effectively refer and link newly diagnosed HIV positive individuals to care. RFP's will also require applicants to describe how proposed program activities support EIIHA goals. The Administrative Agency will initiate a Request for Applications (RFA) procurement process in compliance with Planning Council Guidance and applicable City of Austin policies and procedures. EIS subcontractor(s) will be selected by the City on an objective basis, following review and scoring of applications based on responsiveness to the scope of work and other specific evaluation criteria listed in the RFA.

(1) (d) How ADAP Resources will be coordinated

The Planning Council has a Rapid Reallocation Policy that enables the Administrative Agent to make a timely fiscal response to an emerging need. During the fiscal year, unexpended funds can be reallocated to the Local AIDS Pharmaceutical Assistance program in order to provide rapid response to medication needs of newly diagnosed HIV-infected clients. Again in FY 2012, the City of Austin will enter into an Inter-Local Agreement with the Texas Department of State Health Services (DSHS). Eligibility under this contract will be limited to HIV positive clients residing in the TGA. An Austin TGA representative will also attend regularly scheduled Texas HIV Medication Program (ADAP) Advisory Committee meetings regarding access related issues as well as program changes affecting clients, e.g. eligibility, formulary.

(1) (e) How the strategy addresses disparities in access and services among affected subpopulations and historically underserved communities.

The strategy addresses disparities in access and services among affected subpopulations and historically underserved communities by targeting EIIHA activities to high-risk populations in

the TGA. The high-risk populations targeted are African American Women (AAW), Young Men who have Sex with Men (YMSM), Injection Drug Users (IDUs), and persons Recently Released from Incarceration (RR). Racial and ethnic minority populations make up a disproportionate share of all of the targeted groups.

(1) (f) Programmatic, systemic, and logistical challenges

In order to make individuals aware of their HIV status, they must be tested. The programmatic systemic, and logistical challenges associated with this effort involves finding funds to expand counseling and testing programs, determining proper venues, changing community norms, and addressing the behavioral, cultural, and environment of persons considered at high risk of becoming infected. State legal requirements for HIV testing, discordant federal HIV testing recommendations, public and private health insurance policies, policies inhibiting use of rapid HIV tests, and policies and practices in corrections settings are systemic challenges to HIV testing. The lack of programs and policies to reduce HIV stigma and discrimination are other challenges associated with making individuals aware of their HIV status.

(1) (g) Role of the Ryan White Program in facilitating routine HIV testing within the TGA.

In the Austin TGA, the Ryan White Program's role in facilitating routine HIV testing is to establish and support the EIIHA Collaborative discussed earlier. This collaborative will provide the leadership, advocacy, and gap funding to help facilitate routine testing in the area.

(1) (h) How applicant will coordinate with Ryan White Part C program(s) for the purpose of making HIV unaware individuals aware of their HIV status.

The Austin Travis/County Health and Human Services Department is the Administrative Agency for the Ryan White Part A and Part C programs in the area. This factor will facilitate the coordination of efforts by the agencies in making persons aware of their HIV status.

(2) Austin TGA EIIHA Matrix Listing the Parent and Target Groups

The Austin TGA EIIHA Matrix illustrates how the area's overall unaware population is broken down into specific target groups is included as Attachment 9. It includes all target groups intended to be addressed by the Strategy, Plan, and Data.

2) B. PLAN *(ACTIVITIES, METHODS, AND/OR MEANS UTILIZED TO IMPLEMENT THE STRATEGY)*

(1)(a) & (b) Description the barriers which obstruct awareness of HIV status

<u>African American Women (AAW)</u>

African American Women represent a target group having unique challenges which prevent them from becoming aware of their HIV status. The priority needs to be address for this target group are as follows: The three (3) most difficult challenges associated with making African American women aware of their HIV status are: (1) African American women are not comfortable openly discussing the topic of sexuality from a personal perspective; (2) African American women possess low self worth and self-esteem issues which prohibit them from engaging in and pushing condom use; and (3) African American women who are dealing with the use of drugs or who

have a mental health impairment, mostly undiagnosed, are resistant to outreach activities and public messages that promote testing efforts. Other priority needs impacting this target group are low perception of risk, poverty, lack of access to quality health care, lack of HIV knowledge, high rates of sexually transmitted diseases, and relationship dynamics such as not insisting on condom use with a male partner. Cultural challenges that obstruct awareness of HIV status include: racism, discrimination, and stigma.

Minority Injection Drug Users (IDUs)

Injection drug users are another target group with some unique challenges which prevents them from knowing their HIV status. The priority needs associated with this target group in the Austin TGA are as follows: fear of learning one's HIV status; stigma of being seen at HIV testing sites; culture and language barriers; socioeconomic problems such as poverty, lack of insurance, and stable housing; fear of confidentiality breaches; concerns about undocumented status; lack of basic HIV education; mental illness, continued substance abuse; and timely access to drug treatment. Persons in this target group are from all of the major ethnic/racial groups in the area and the cultural challenges which obstruct their HIV awareness status include: racism, discrimination, stigma, immigration status, and homophobia.

Young Men who have Sex with Men (YMSM) Ages 13-34

Young gay, bisexual, and other men who have sex with men make up the greatest proportion of persons unaware of their HIV status in the Austin TGA. The priority needs or barriers to knowing their HIV status for this target group are as follows: underestimating personal risk; belief that HIV treatment minimizes infection risk; substance use; complacency about HIV; fear of stigma and homophobia; multiple sex partners, often anonymous; lack of awareness about risk of HIV infection; high risk taking behaviors; insufficient access to information on HIV counseling; testing; condom use; harm-reduction strategies; and treatment and care for sexually transmitted infections. Persons in this target group are from all of the major ethnic/racial groups in the area. The cultural challenges which obstruct their HIV awareness status include: racism, discrimination, stigma, immigration status, language barriers; and homophobia.

Recently Released from Incarceration (RR)

The priority needs or barriers to knowing their HIV status for this target group are as follows: testing individuals upon entering the prison/jail system; substance use; lack of awareness about risk of HIV infection; high risk taking behaviors; insufficient access to information on HIV counseling; testing; condom use; harm-reduction strategies; and treatment and care for sexually transmitted infections.

Issues related to privacy, confidentiality, and stigma-induced reprisals have also been cited as barriers which obstruct awareness of HIV status. HIV Prevention efforts will be more successful if offenders have access to needed care and services and the opportunity to successfully transition from incarceration to the community. Persons in this target group are composed of all of the major ethnic/racial groups in the area, but people of color are disproportionately represented. The cultural challenges which obstruct their HIV awareness status include: racism, discrimination, stigma, immigration status, language barriers; and homophobia.

(2)(a) Priority needs activities to address barriers that obstruct awareness of HIV status
Table1 and 2 below describes activities, timeline(s), and responsible parties for addressing priority needs and cultural challenges of the target groups.

Table 1: Priority Needs Activities

Activities Addressing Barriers that Obstruct Awareness of HIV Status	Target Group	Time Frame	Responsible Party(ies)
Complete Inventory of Existing IDUs Service Providers	IDU	2011-12	AAHPC
Advocate for Needle Exchange Programs in the TGA	IDU	2011-12	Task Force
Continue Street Outreach Initiatives	All	2011-12	AAHPC/Task Force
Initiate Social Marketing Campaign	All	2011-12	ATCHHSD
Initiate Targeted Social Marketing Campaign	All	2011-12	ATCHHSD
Coordinate HIV Testing Sites and Organizations	All	2011-12	Task force
Expand Op-out testing initiatives	All	2011-12	Health Care District
Continue Prevention Case Management Program	All	2011-12	ATCHHSD
Continue Partner Notification Programs	All	2011-12	ATCHHSD
Continue Condom Availability/Accessibility Initiatives	All	2011-12	Existing Providers
Continue HIV Counseling & Testing Program	All	2011-12	ATCHHSD
Continue Mobile Van Outreach Initiatives	All	2011-12	Existing Providers

(2)(b) Activities to address cultural challenges

Table 2: Cultural Challenges Activities

Activities Addressing Cultural Challenges that Obstruct Awareness of HIV Status	Target Group	Time Frame	Responsible Party(ies)
Continue incorporating Culturally and Linguistically Appropriate Services(CLAS) standards in the TGA	All	2011-12	ATCHHSD
Continue SISTA EBI		2011-12	Prevention Providers
Continue Healer Women EBI		2011-12	Prevention Providers
Continue VOICES EBI		2011-12	Prevention Providers
Continue Fresh Start EBI	AAW	2011-12	Prevention Providers
Continue the "Q" Mpowerment EBI	MSM	2011-12	Prevention Providers
Continue Community Promise EBI		2011-12	Prevention Providers
Continue the RAPP EBI	AAW	2011-12	Prevention Providers
Continue the Substance Abuse Treatment Program	IDUs	2011-12	Treatment & Care Provider

(3) Actions taken to facilitate HIV testing in the EMA/TGA.

(a) Coordination with other organizations to facilitate HIV testing.

See page 24 for a description of efforts to facilitate HIV testing.

(b) Role of Early Intervention Services in facilitating HIV testing.

The Planning Council is currently employing a strategy to identify HIV positive individuals who are unaware of their status; to help reduce disparities; to increase access to medical care; and to improve health outcomes by funding the Early Intervention Services (EIS) category. Funds allocated for EIS are intended to provide outreach services to persons unaware of their status. A local AIDS Services Organization will implement the strategy.

(4) Identifying, Informing, Referring, and Linking

(a) Essential and non essential activities which will be used to identify HIV positive unaware individuals

ESSENTIAL ACTIVITIES	I or PNI	Time Frame	Responsible Party(ies)
Complete Inventory of EIIHA Services and Identification of Service Gaps	I	2011-12	AAHPC
Identification of EIIHA Collaborative Members	PNI	2011-12	Task Force
Continue current outreach and testing initiatives	I	2011-12	AAHPC/Task Force
Continued funding of Part A EIIHA Outreach Services	I	2011-12	ATCHHSD
Continued funding of Part C Early Intervention Services	I	2011-12	ATCHHSD
Begin collaboration and coordination with EIIHA Outreach and Testing Service Providers	I	2011-12	Task force
Facilitate Quarterly EIIHA Collaborative Meeting	I	2011-12	Health Care district
Advocate for mandatory HIV testing procedures upon entering and exiting the penal system	I	2011-12	ATCHHSD
Internet-based messaging to MSM, encouraging HIV testing and importance of knowing your status	I	2011-12	Existing Providers
Encourage HIV testing among MSM at least once every twelve months, and more frequently for MSM who engage in high risk behaviors	I	2011-12	ATCHHSD
Increase awareness among healthcare providers of the need to provide annual HIV testing for all MSM patients, and more frequent HIV testing for minority MSM who are more likely to be infected and unaware of their status	I	2011-12	ATCHHSD
Targeted HIV awareness micro-campaigns within the MSM target group	I	2011-12	ATCHHSD
Develop a collaborative relationship w/key officials working in the local and state penal system	I	2011-12	Task Force
Establish a grassroots advocacy group to bring awareness to the importance of HIV testing in jails/prisons	I	2011-12	Task Force
Update and publish a new Resource Guide that contains relevant resources for the prisoner/jail population	I	2011-12	AAHPC
Create a list of jails/prisons in the TGA and provide with Resource Guides in bulk	I	2011-12	ATCHHSD
NON ESSENTIAL ACTIVITIES		**Time Frame**	**Responsible Party(ies)**
Update Comprehensive Plan to include specific achievable coordinated activities, deliverables, and timeline related to the identification of HIV positive unaware individuals, making them aware of their HIV positive status, and linking them to care	PNI	TBD	TBD
Complete feasibility study of using peers in outreach programs	PNI	TBD	TBD
Seat HIV Partner Notification and Prevention Specialist on the Planning Council	PNI	TBD	TBD
Design social media websites targeting AAW: Face book, Twitter, etc.	PNI	TBD	TBD
Develop cultural and linguistic competency training for non-HIV service providers who are likely to have frequent contact with the MSM target group	PNI	TBD	TBD
Convene a community discussion series on relevant AAW topics	PNI	TBD	TBD
Implement parent circles to help women educate their children on topics of sexuality and HIV	PNI	TBD	TBD

I=Implementing; PMI=Proposed but Not Implemented; TBD=To be Determined

Description of parties responsible for ensuring each of the essential activities is implemented according to the timeline
The AAHPC, the Grantee, and the EIIHA Collaborative will jointly be responsible for ensuring that the essential activities are implemented according to the timeline.

Description of RW Part B coordination
The Part B Grantee, the Texas Department of State Health Services (DSHS), and Part A Grantees meet on a quarterly basis to collaborate in addressing common service delivery issues. DSHS's EIIHA Plan is will be coordinated with the Part A plans after completion.

Progress from Previous Year: The Brazos Valley Council of Governments (BVCOG) is the counterpart to the Austin/Travis County HHSD. BVCOG serves as the Part B Administrative Agency for a multi-county area which includes the Austin TGA. The HIV Services Planner at BVCOG is a member of the Austin HIV Planning Council. This relationship enhances program planning and service delivery coordination between the Part A and Part B administrative agencies. EIIHA activities are provided in the rural areas of the TGA by BVCOG through a contract with Community Action, Inc. Targeted outreach and testing activities have been coordinated by Community Action, Inc. Through coordination and collaboration with other HIV testing organizations in the rural areas, high-risk HIV positive unaware individuals have been tested and made aware of their status.

Description of coordination with prevention and disease control/intervention programs
The Austin/Travis County Health and Human Services Department (A/TCHHSD), because of its legislatively mandated surveillance and disease intervention role, is a key provider of services to the HIV unaware, along with three HIV services agencies located in Austin and one agency serving the rural areas of the TGA. Many of these activities are performed by disease intervention specialists, who are responsible for partner notification, and include referral for HIV testing. In addition to their early identification activities, these HIV services agencies provide a range of services including Ryan White Program Part A, B, & C core medical and health-related support services, as well as CDC funded HIV prevention activities.

Progress from Previous Year: Ryan White Part A Administrative Agency and Prevention staff met several times during the year to exchange data and discuss coordination activities. The Travis County Health Care District has expanded Opt-Out testing in all of its clinics.

(b) Informing Individuals of their HIV status
The TGA's plan to inform unaware individuals of their HIV status is to use existing methods and service providers. Coordinating activities among these providers is expected to increase the number of clients informed of their status. The TGA's overall strategy and goals for informing are general and applicable to each of the target groups.

Activities specific to achieving these goals will be based on characteristics and other high-risk behavioral factors both common and unique to each group. Informing unaware individuals will be customized based on their specific needs and challenges as shown by the planned activities for each group discussed below. Coordinating and collaborating with existing organizations will enable more clients to be informed of their status.

The major challenges associated with informing the entire target groups of their status are as follows: busy practice environments; length of time to confirm test results; getting all groups to return to get results; anonymous testing policies; privacy and confidentially issues; and language and cultural barriers. Other challenges are the inability to follow-up with the target group populations through traditional communication means, due to disconnected home phones, inactive cell phones, and issues related to the transient nature of the individuals. Unstable housing is also a constant challenge.

Essential and non essential activities which will be used to inform HIV positive unaware individuals of their status

The essential activity to inform each of the targeted target groups of their HIV status is to use the existing methods and organizations. Most of the organizations provide testing in publicly-funded sites. These sites include health care settings (such as ATCHHSD public health department clinics, drug treatment facilities, family planning clinics, prenatal clinics, STD clinics, and community health clinics) and non health care settings (counseling and testing sites, support services providers). After test results are received, trained personnel at testing sites will continue to inform individuals of their results.

ESSENTIAL ACTIVITIES	I or PNI	Time Frame	Responsible Party(ies)
Ensure that Counseling and Testing staff are culturally and linguistically competence	I	2011-12	ATCHHSD
Continue Protocol-Based Prevention Counseling and Testing services	I	2011-12	ATCHHSD
Continue Comprehensive Risk Counseling Services(CRCS)	I	2011-12	ATCHHSD
Ensure that organizations providing counseling and testing activities meet CLAS standards	I	2011-12	ATCHHSD
Ensure that privacy and confidentially laws do not become barriers to informing sup-group populations of their HIV Status	I	2011-12	ATCHHSD
Expand Rapid Testing Initiatives	I	2011-12	Task force
Develop a centralized and progressive communication system to inform (e.g. step 1-call, step 2-visit, etc.)	I	2011-12	ATCHHSD
NON ESSENTIAL ACTIVITIES		**Time Frame**	**Responsible Party(ies)**
Research and determine the feasibility of implementing the Louisiana Public Health Information Exchange (LaPhie) model in the FQHCs	PNI	TBD	TBD
Research and determine the feasibility of using peers to assist in informing individual in each target group of their HIV status	PNI	TBD	TBD
Expand the number of counseling and testing sites and ensure staff are thoroughly trained in laboratory procedures, interpreting preliminary results and reporting results	PNI	TBD	TBD

I=Implementing; PMI=Proposed but Not Implemented; TBD=To be Determined

Responsible parties for ensuring each of the essential activities are implemented according to the timeline

The AAHPC, the Grantee, and the EIIHA Collaborative will jointly be responsible for ensuring that the essential activities are implemented according to the timeline.

RW Part B Coordination

Part B coordination and progress was discussed above on page 30.

Coordination with prevention and disease control/intervention programs
Coordination with prevention programs and progress were discussed above on page 30.

(c) Referring to medical care and services
The plan to refer high-risk HIV positive individuals to care takes a variety of forms depending on the needs of the newly diagnosed client. In the Austin TGA, the majority of referrals into medical care or other HIV support services are done through its case management system. HIV counseling and testing staff, client advocates and non-medical case managers provide advice and personal assistance in referring to medical and support services.

Essential activities which can be implemented immediately to refer HIV positive unaware individuals of their status
The essential activities which will be used to refer HIV positive unaware individuals to care are listed below. Some of the activities are designed to improve the overall system while other center on addressing client barriers to being referred.

ESSENTIAL ACTIVITIES	I or PNI	Time Frame	Responsible Party(ies)
Coordinate and standardize the referral process at all case management service providers	I	2011-12	ATCHHSD
Coordinate the referral process at correctional institutions	I	2011-12	ATCHHSD
Initiate HIV/AIDS stigma reduction activities	I	2011-12	ATCHHSD
Initiate social marketing campaign plan	I	2011-12	ATCHHSD
Ensure that services are available and accessible	I	2011-12	ATCHHSD
Educate all target group populations on the availability of HIV care and drug treatment programs	I	2011-12	Task force
Educate all target group populations on the cost of care and treatment	I	2011-12	ATCHHSD
Increase service provider knowledge	I	2011-12	Task force
Create a survey tool to assess healthcare provider preferences	I	2011-12	Task force
Develop memorandums of understanding between referral organizations	I	2011-12	Existing Providers

I=Implementing; PMI=Proposed but Not Implemented; TBD=To be Determined

Responsible parties for ensuring each of the essential activities is implemented according to the timeline
The EIIHA Collaborative, Grantee, and AAHPC will be jointly responsible for ensuring that essential activities are implemented according to the timeline.

RW Part B Coordination
Part B coordination and progress was discussed above on page 30.

Coordination with prevention and disease control/intervention programs
Coordination with prevention programs and progress were discussed above on page 30.

(d) Linking to Medical Care: Essential and non activities for ensuring access to medical care regardless of where any newly identified HIV positive individuals enters the continuum of care

The plan for linking all of the groups to care will be done by utilizing the TGA's case management, outreach, and testing systems operated by existing service providers. Essential activities are listed below. There are currently not any non-essential activities listed.

ESSENTIAL ACTIVITIES	I or PNI	Time Frame	Responsible Party(ies)
Coordinate services required to implement service plans by referring clients to appropriate resources and ensuring linkages	I	2011-12	Existing providers
Ensures linkage by educating clients about eligibility criteria and process	I	2011-12	Existing providers
Assisting in completion of applications	I	2011-12	Existing providers
Advocating on the client's behalf	I	2011-12	Existing providers
Following up on referrals to monitor client progress and address barriers, as needed	I	2011-12	Existing providers
Research and determine if ARIES can be used to enhance the linkage to care process	I	2011-12	ATCHHSD
Continue funding case management/case coordination activities in the TGA	I	2011-12	ATCHHSD
Coordinate service provider linkage to care activities	I	2011-12	ATCHHSD

I=Implementing; PMI=Proposed but Not Implemented; TBD=To be Determined

Responsible parties for ensuring each of the essential activities is implemented according to the timeline

The EIIHA Collaborative, Grantee, and AAHPC will be jointly responsible for ensuring that essential activities are implemented according to the timeline.

RW Part B Coordination

Part B coordination and progress were discussed above on page 30.

Coordination with prevention and disease control/intervention programs

Coordination with prevention programs and progress were discussed above on page 30.

Activities undertaken (post-referral) to verify that care/services were accessed for newly identified HIV positive individuals

All newly identified HIV positive individuals undergo agency intake and assessment procedures. Case management staff verifies access to services by confirming appointments were kept when meeting with clients and also following up with care/service provider agencies to confirm.

Essential activities

During this process, clients sign a document allowing the agency to share or not to share their information with other agencies providing HIV services. Client level services data are entered into ARIES. If client agrees to share information, agency staff can use ARIES to verify access to

medical or support services electronically. If clients do not agree to share information, they are required to get referral service providers to sign forms documenting receipt of services. These forms are returned to the referring service provider.

Proposed activities
The TGA will investigate the use of case coordinators or peers as members of a care coordination team who would assist clients in keeping appointments and in the verification of care. The essential activities described above will continue to be provided in FY 2011-12 and thereafter. The AAHPC, grantee, and the EIIHA collaborative will ensure that the essential activities will be carried out during the FY11-12 time period.

Activities undertaken to form and maintain relationships with private HIV care providers for the purpose of verifying that individuals referred into private care have accessed care post-referral
TGA service providers have developed working relationships with private care providers over the years. These relationships have enabled providers to refer clients to care and receive information on the care received by clients.

Essential activities
Case managers in the TGA have developed relationships with the Blackstock clinic, local hospitals, physicians in private practice serving individuals with HIV, and correctional facilities. Blackstock is the largest private clinic providing primary medical care to HIV positive individuals in the area. Currently, the relationships are informal and verification that services have been accessed is intermittently collected.

Proposed activities
The EIIHA Collaborative will target more participation from private sector organizations and private practices to expand the TGA's ability to identify and link more HIV positive unaware individuals into care and to obtain verification that service was accessed by patients referred for care. Initiation of more private sector participation will continue in FY2012.

Progress from previous year: The Administrative Agency facilitated a CME training for medical providers on HIV care in collaboration with the Texas/Oklahoma AIDS Education and Training Center and included information on patient referral and follow-up. Additionally, in FY10-11, administrators from the Blackstock clinic participated in several HIV stakeholder planning meetings and provided valuable input into the process.

2) C. Data
Data on individuals receiving EIIHA services are capture and shared in the following manner. Staff members at local, state, and federally funded testing sites collect information about the number of tests provided, the results of those tests, and information about the demographics and behavioral risk factor of those persons tested. After unaware persons are tested and confirmed positive, they are entered into the HIV/STD surveillance system in Texas. The Enhanced HIV/AIDS Reporting System (eHARS) captures HIV/AIDS data to monitor the epidemic in Texas and to report required data to CDC to monitor the epidemic nationally. eHARS incorporates major advances in database organization and data presentation and is a document

based system, meaning that data from multiple documents are entered for each case and those documents are linked with a unique identification number. eHARS enables the HIV/AIDS surveillance program to gather and store information from birth certificates, death certificates, and laboratory reports. Finally, eHARS allows for evaluation of data pertaining to HIV and AIDS case ascertainment methods.

Once an unaware person is connected to care (i.e., support services or primary medical care) client level data is entered into the AIDS Regional Information and Evaluation System (ARIES). ARIES collects and reports demographic, clinical, and service utilization data. Examples of demographic data collected include race, ethnicity, date of birth, gender, city, county and state of residence, ZIP code, living situation, financial, and insurance information.

A number of clinical data elements are also available in the system, including CDC disease stage, risk factors, CD4's, viral loads, sexually transmitted infections (STI), hepatitis, tuberculosis, (including multi-drug resistant TB), immunizations, ART therapy, and medications taken to treat/prevent opportunistic infections. ARIES enhances the provision of HIV services by helping providers automate, plan, manage, and report on client data.

(1) The estimated number of living HIV positive individuals who were unaware of their status in calendar year ending December 31, 2009 was 1,110 according to the Texas Department of State Health Services. The Back Calculation (EBC) methodology was used.

i) Summary:

National Proportion Undiagnosed = 21%

$$\frac{.21}{(.79)} \quad X \quad 4{,}177 \text{ (diagnosed living)} = 1{,}110 \text{ (undiagnosed)}$$

(2) Coordination with Ryan White Part B
DSHS is the Part B Grantee for the state of Texas and operates the ARIES and e-HARS systems. Local Part A, B and prevention providers can access and share data after input into the systems. As stated earlier, the majority of treatment and care agencies in the TGA, also provide prevention services. The Part B Administrative Agency has a representative who sits on the Part A Planning Council and there are quarterly coordination meetings between the Part A and B Administrative Agencies to exchange data.

(3) Coordination with disease control and prevention/intervention
The vast majority of disease control and prevention/intervention programs are conducted through A/TCHHSD. Since A/TCHHSD is also the Ryan White Program Grantee, management staff from each area meets on a regular basis to coordinate activities and share data.

3) Access to HIV/AIDS Care and the Plan for FY 2012

TGA's Established Continuum of HIV/AIDS Care and Access to Care
The current system of care in the Austin Transitional Grant Area (TGA) is supported by what Planning Council termed the pillars of "Access" and "Address." The pillar of Access establishes mechanisms that promote the availability of affordable and equitable healthcare for newly affected and underserved populations, thereby leveling the healthcare playing field. Likewise, the pillar of Address provides a systematic approach that takes into account the service needs of special populations, including communities of color that are disproportionately impacted, emerging populations, and out-of-care individuals who know their HIV status. Together, the two pillars provide a deliberately constructed framework that facilitates the continuum of care's affect in producing maximum health outcomes for all clients.

3) A. Table: FY 2012 Implementation Plan
The FY 2012 Implementation Plan Table is Attachment 7.

3) B. FY 2012 Plan Narrative

(1) How the TGA links its latest needs assessment (including results of the HRSA/HAB Unmet Need Framework), Comprehensive Plan, service priorities, and the FY 2012 Implementation Plan

The FY 2012 Plan is designed to support the continuum of care discussed above with Part A funding for the listed service categories. As shown in the FY 2012 Implementation Plan Table, funding emphasis has been placed on four core medical service categories: Outpatient/Ambulatory Medical Care; Oral Health Care; AIDS Pharmaceutical Assistance–local; and Mental Health Services. Two support services also are addressed: Case Management Services–Non-Medical Tier 1 (Psychosocial Case Management) and Tier 2 (Patient Navigator); and Substance Abuse Services–Residential. Finally, MAI funds primarily support Medical Case Management and Case Management Services–Non-Medical Tier 1 and Tier 2. These services facilitate access and continued engagement in medical care, thus maximizing health outcomes.

Altogether, the highest funded core and support services listed in the FY 2012 Implementation Plan are consistent with goals outlined in the Austin TGA's current Comprehensive Plan, as well as with findings from 2010 Comprehensive Needs Assessment. For example, contained within the Comprehensive Plan are specific goals and objectives developed by the Planning Council to ensure the availability of quality core and support services to eliminate disparities in access for disproportionately affected sub-populations and historically underserved communities. FY 2012 funding decisions reflect an increase in non-medical case management from the previous year, based in part on the service needs identified by a significant number of surveyed minority respondents in the 2010 Comprehensive Needs Assessment project. This component of the plan was developed to ensure increased access to the HIV continuum of care for special populations, including minority communities impacted by disproportionate HIV prevalence.

(2) Identify any prioritized Core Medical Services which will not be funded with Ryan White Program funds and how these services will be delivered in the TGA
Based on the Planning Council's priority setting and resource allocations process, there were no services in the top 10 priorities that were not funded for FY 2012. Only two (2) core services in

the top 25 priority listing (Home Health Care ranked 23; Home and Community Based Health Services ranked 22) were at zero funding. Both of these services were identified as being sufficiently funded through public and private insurance options and other sources.

(3) How the activities described in the plan will provide increased access to the HIV continuum of care for minority communities

The Austin TGA's high HIV prevalence rate in minority communities creates a profound and disproportionate affect on those living with HIV/AIDS. The specific issues and burdens faced by minority communities are detailed in the Demonstrated Need section. The FY 2012 Plan is designed to increase access to the HIV continuum of care for minority communities through the TGA's Minority AIDS Initiative (MAI) programs and through the activities outlined in the Comprehensive Plan. Findings from the Comprehensive Needs Assessment and additional recommendations also inform the FY 2012 Plan regarding access. For example, psychosocial support was identified in the Needs Assessment as a support service for African Americans that would enable them to access and stay in care. In response, the Planning Council has ensured that the function of support is delivered through psychosocial support groups. Similarly, MAI funding resources and activities target two minority populations: Hispanic and African American. These two communities are found to have a higher burden of poverty, are reluctant to enter the system of care, and prone to fall out of medical care if not provided with extensive support services and personal intervention. Immigrant Hispanic clients face immigration issues and language barriers in accessing services. Furthermore, African Americans in the TGA have a higher proportion of substance abuse issues in comparison to other racial/ethnic groups.

(4) How the activities described in the plan will address the needs of emerging populations, as discussed in the demonstrated needs section

The needs of the following priority populations were examined in the Comprehensive Needs Assessment: African American men and women, Hispanic men and women, injection drug users, non-injection drug users, the out-of-care population, White men who have sex with men, (MSM), men of color MSM, persons recently released from jail/prison, rural residents, and youth. The FY 2012 Plan focuses on unmet need and service gaps experienced by the aforementioned emerging populations. Each population represents unique challenges that must be addressed in order to improve HIV health outcomes. For example, one initiative supported by the Planning Council is a strategic planning effort among community stakeholders, particularly those working in the HIV prevention arena. A primary purpose of the strategic planning initiative is to address health disparities in the minority community. The overarching goal in the Austin TGA is to develop and implement evidence-based strategies consistent with those outlined in the National HIV/AIDS Strategy.

(5) How the activities described in the plan will encourage PLWH/A to remain engaged in HIV/AIDS primary medical care and adhere to HIV treatments

The Planning Council identified two services that were key to PLWH/A remaining engaged in primary medical care and adhering to HIV treatments:

Medical Case Management including Treatment Adherence Services

The Care Strategy Committee first designated Medical Case Management, along with treatment adherence, as an "essential" service category which promotes the likelihood of PLWH/A remaining in primary medical care. The Planning Council continues to recognize that treatment

adherence services are crucial for successful antiretroviral treatment. Therefore, several factors were considered to encourage PLWH/A to remain engaged in HIV/AIDS primary medical care. PLWH/A who adhere to treatment regimes are more likely to experience an improved CD4 cell count and viral load suppression, and less likely to develop drug-resistant virus. In addition, the Planning Council determined that treatment adherence counseling cannot be addressed satisfactorily through outpatient medical care services alone due to rising demand for services and stagnant or reduced funding. The increasing complexity of care for PLWH/A means that there is less time in primary care visits to fully address issues such as treatment adherence.

AIDS Pharmaceutical Assistance–local

Clients who are out of care and attempting to enter or re-enter the care system face many challenges in obtaining antiretroviral medications. In the HIV Needs Assessment, survey respondents were asked to rate the services based on their "importance to you." Drug reimbursement/pharmaceutical assistance was the fourth most important service identified:

- Among in-care consumers, the seventh most frequently identified need and the sixth most frequently identified unfulfilled need;
- Among African-American women and women of childbearing age, the fourth most frequently identified unfulfilled need; and
- Among White MSM, the fifth most frequently reported need.

Over recent funding cycles, the allocation to AIDS Pharmaceutical Assistance has steadily increased in the TGA. For FY 2012, the allocation pattern continues, providing consistency in funding for local AIDS Pharmaceutical Assistance allows the Planning Council to track utilization trends and, subsequently, effectively respond to the medication needs of PLWH/A.

(6) How the activities described in the plan will promote parity of HIV services throughout the TGA. Parity of services should be addressed in terms of geographic location of services, quality, comprehensiveness of services, and cultural appropriateness

Geographic parity is addressed by continuing to give priority for funding to providers located in heavily impacted areas. Households receiving public assistance and with high rates of poverty and unemployment are heavily concentrated in tracts east of Interstate-35, south of the Colorado River, and surrounding the University of Texas campus. The majority of residents in these neighborhoods are African American and Hispanic. All of the Ryan White Part A service providers in Travis County are located within these geographic areas. Moreover, parity in quality of services is also addressed by establishing quality of care guidelines and examining research on quality of care issues that impact special populations. The Planning Council received research reports on physician-to-patient ethnic concordance and quality of care, the impact of treatment adherence programs on quality of care, and the impact of cultural competency training on quality of care. The Planning Council used these reports in determining service and funding priorities to establish the 2009-2011 Comprehensive Plan goals and objectives. Finally, the comprehensiveness of services is addressed in the continuum of care model, which links all services in a manner that brings people into primary care and maintains them in care. It categorizes services based upon how they serve the specific needs of clients, particularly those out of care.

(7) How the activities are assuring the services delivered by subcontractors are culturally and linguistically appropriate to the population served within the TGA

The Planning Council strives to meet the challenges posed by populations with special cultural or linguistic needs by establishing a system which effectively addresses and eradicates existing

barriers to care. Primarily accomplished through the work of the Planning Council's Evaluations/Quality Management and Care Strategy Committees, services are assessed and studied through client surveys and public forums hosted by the Planning Council. The committees' joint responsibilities include: investigating out-of-care issues, documenting barriers to care, documenting special needs such as cultural proficiency issues, and working with the Administrative Agency's Quality Management Coordinator to study standards of care and other issues. The Planning Council's goal is to attain a high level of cultural proficiency reflective of the composition of the communities served. In order to achieve this level, there is ongoing review and revision of cultural competency, sensitivity, and proficiency standards for the provision of services funded by Ryan White Part A.

(8) How the services and their goals/objectives relate to goals of Healthy People 2020 initiative
The Planning Council has identified the following two overarching goals in its current Comprehensive Plan:

- GOAL 1: a) To engage out-of-care persons living with HIV/AIDS (PLWHA) and maintain in-care PLWHA in the system of care by providing full access to medical care and other eligible core service; and b) Administration of care shall focus on cultural competency, sensitivity, and proficiency; removal of existing barriers; and evidence-based strategies that target underserved and hard to reach populations.
- GOAL 2: a) To optimize the continuum of care by ensuring all Ryan White funded services, particularly mental health therapy and substance abuse treatment, are of the highest quality; and b) coordinated with non-Ryan-White organizations for linkage to other funding sources.

These two overarching goals address the service needs, gaps, and barriers to care consistently identified in previous needs assessments, as well as in the most recent Comprehensive Needs Assessment. In order to reach each goal, a comprehensive list of objectives is included in the Comprehensive Plan. Each objective has long and/or short-term activities, action steps, strategies, or initiatives designed to maintain and improve the TGA's system of HIV care. Finally, the FY 2012 Implementation Plan goals and objectives are responsive to the Healthy People 2020 Objectives for HIV Infection as shown in the table below.

Table A: Relationship between Healthy People 2020 HIV Objectives and FY 2012 Plan

Healthy People 2020 Objectives for HIV Infection	Related Goals FY 2012 Implementation Plan
HIV-1-3: (Developmental) Reduce the number of new HIV diagnoses among adolescents and adults.	Goal 1.a. & 2.b.
HIV- 4, 6: Reduce the number of new AIDS cases among adolescent and adult MSM.	Goal 1.a. & 2.b.
HIV-7: Reduce the number of new AIDS cases among adolescent and adult MSM and IDU.	Goal 1.a., 1.b. & 2.b.

(9) How the TGA will ensure that resource allocations for services to women, infants, children, and youth (WICY) are in proportion to the percentage of TGA AIDS cases represented by each population
HIV services providers contractually are required to submit units of service delivered to WICY populations by entering data in the AIDS Regional Information and Evaluation System (ARIES).

This system captures various levels of service utilization and spending data on every client served including age, gender, date of service delivery, number of units delivered, and HIV service objectives. Data show the utilization of primary medical care and health-related support services for these four specific populations. To track the amount expended, the number of actual units delivered is multiplied by the unit cost for each service objective for each WICY population. The actual amount of Part A funds expended on each WICY priority population is monitored by the Administrative Agent and reported to the HIV Planning Council and to HRSA as required in the Part A and B Ryan White HIV/AIDS Program Guidelines for Implementing the Minimum Expenditure Requirement to Provide Services to Women, Infants, Children and Youth.

(10) How the TGA Planning Council or community planning process is using Minority AIDS Initiative (MAI) funding to reduce disparities in access to care, to further enhance the quality of care and health outcomes in communities of color disproportionately impacted by the HIV epidemic, and how those activities are integral to the overall Part A FY 2012 plan

MAI-funded activities are an integral part of the overall FY 2012 Implementation Plan. The Planning Council leverages MAI funds to support programs designed to improve client care quality and health outcomes for members of targeted minority racial and ethnic communities. African Americans and Hispanics are two of the populations most disproportionately impacted by HIV/AIDS in the Austin TGA. Quality of care can be linked to client satisfaction; therefore, to gauge the relative effectiveness of MAI-funded services, the Planning Council routinely assigns a standing subcommittee to study and address results from the current year's client satisfaction survey. In the past, the two service categories that were supported with MAI funds were outreach and non-medical case management. For the FY 2012 Plan, findings indicated an additional service would be funded with MAI funds: Medical Case Management including treatment adherence. Whenever appropriate, the Planning Council issues directives about how the services are provided in order to enhance the quality of services. Quality of care standards and service category performance measures are also used to determine whether intended client health outcomes are being achieved.

An additional strategy employed by the Planning Council to help reduce disparities, increase access, and improve health outcomes is the continued allocation of a portion of resources for outreach to the Early Intervention Services (EIS) category. Funds allocated for EIS are intended to provide a broad array of activities that will effectively identify eligible PLWH/A and link them to care, thus increasing the likelihood of positive client-level health outcomes. Finally, MAI funding will be used to reduce disparities by considering and using as a basis, specific strategies outlined in the National HIV/AIDS Strategy. As noted in the Strategy, *"there are differences in health care access and treatment outcomes by race/ethnicity . . . access to care and supportive services are particularly difficult for HIV-positive persons in rural areas."* Through the support of MAI funding, the Austin TGA plans to respond to the unique issues faced by African American and Hispanic PLWH/A, by *"taking deliberate steps to increase the number and diversity of available providers of clinical care and related services for people living with HIV."* This step will be taken through strategic capacity building efforts for local gatekeepers and HIV-service providers not currently or historically funded through the Ryan White Part A Program. The goal is to reach HIV positive minorities who are out-of-care or unaware, by expanding the venues that currently exist.

(11) How the results of the Unmet Need analysis was utilized by the planning council or community planning body and impacted in their allocation decisions

The Unmet Need Framework (Attachment 6) was used to project the number of FY 2012 Part A clients out-of-care and to produce a demographic breakdown of the out-of-care minority populations. Illustrating nearly 1,100 PLWH/A with unmet need, the Unmet Need Framework details the exposure groups of IDU and MSM/IDU representing a significant percentage (over 50%) of those with unmet need. This information further supports allocations efforts directed towards the emerging populations of MSM and IDU. As reflected in the Planning Council's final allocation decisions, Substance Abuse Outpatient Services was increased by almost 5% from last year's allocation.

(12) Describe how the planning council or community planning body considered/addressed the need of HIV medications by the target population during their Part A funding allocation process

As the Planning Council's allocation amount to local AIDS Pharmaceutical Assistance demonstrates, HIV medications are an essential component to the Austin TGA system of care. Of particular note is the critical role of HIV medication issues in the lives of target populations including minorities, the recently incarcerated, IDU, and youth MSM PLWH/A. For the estimated 21% who are not aware of their HIV status, antiretroviral drugs can serve as a lifeline to well-being and a sustained quality of life. The Planning Council also considered the service utilization data of corresponding populations currently in care. For example, data indicated Hispanic MSM in the youth category accessed HIV medication services at a lower rate than White MSM in the same age group. Based on this information, the Planning Council increased the funding for AIDS Pharmaceutical Assistance, with a projection that the outreach to underrepresented populations would increase utilization.

(13) Describe how the Planning Council or community planning body considered/addressed the population groups identified in EIIHA, persons who are unaware of their HIV status during their Part A funding allocation process

The Planning Council's work was guided by a fundamental responsibility to leverage Ryan White Part A funds in providing quality medical care to all PLWH/As and increasing access to medical care for all affected in the TGA. However, the specific populations outlined in the EIIHA Matrix, African American Women, Incarcerated Population, MSM of youth age, and Intravenous Drug Users were the primary focus of the Planning Council's decision-making. The Allocations Committee reviewed current and historical unit cost data and information on other funding sources for the Part A service categories that the Needs Assessment identified as being most needed by the EIIHA population groups. Furthermore, utilization data sorted by the frequency of use for these populations was considered during the funding allocation process. Building upon the Needs Assessment Committee's work of assessing the need for each service category prioritized, the Allocations Committee proceeded with using various documented indicators including unit cost, units per client, and ability to contribute to the requirements outlined in Early Identification of Individuals with HIV/AIDS (EIIHA).

4) Grantee Administration

4) A. Program Organization

(1) Administrative Overview

The Chief Elected Official (CEO) of the five-county Austin TGA is the Mayor of the City of Austin, Texas. CEO responsibility for the Ryan White Program Part A and Minority AIDS Initiative (MAI) funds is designated to the Mayor in accordance with an Interlocal Cooperation Agreement between the City of Austin and Travis County. In the Agreement, the CEO assigns Administrative Agent responsibilities for the Ryan White Program Part A to the Austin/Travis Health and Human Services Department (A/TCHHSD) which has appointed its HIV Resources Administration Unit (HRAU) as the entity responsible for performing Ryan White Program Part A and MAI administrative functions.

The relationship of the Administrative Agent to the CEO is shown on the Organizational Chart, followed by the Staffing Plan, Position Descriptions, and Biographical Sketches Table which describes all positions funded by Ryan White Part A (see Attachment 1). Staff shown under Administrative Services provide fiscal assistance but are not funded by the grant. Funding streams administered by the HRAU include: Ryan White Part A and MAI, Ryan White Part C, Housing Opportunities for Persons with AIDS (HOPWA), and City of Austin HIV Services. HIV Planning Council staff is responsible for supporting the Council in fulfilling its legislatively mandated roles and responsibilities including needs assessment, priority setting, planning, and resource allocation. In order to better align staffing with Part A Program requirements, position analysis is currently underway for the two vacant positions: Planner and Quality Management Coordinator. After reassessing the scope of job functions and preferred qualifications, the positions will be posted. The hiring process should be completed by the end of 2011.

(2) Process and Mechanisms to Avoid Duplication

The Administrative Agent is able to track Ryan White Part A and MAI service utilization and expenditures separately across all service categories and service objectives using the client-level database, AIDS Regional Information and Evaluation System (ARIES). Ryan White Part B and Part C expenditure data also are entered and tracked in ARIES. The Austin TGA does not receive Part D or Part F funding. ARIES enables the Administrative Agent to capture demographic, service utilization, and expenditure data for each unduplicated client including date of service delivery, number of service units delivered, service unit cost, funding source, and total amount of funds expended. One unit of service for each HRSA service category is defined by the *Texas Department of State Health Services Glossary of HIV Services*. When a service provider enters a unit of service in ARIES, it can be assigned to only one funding source. Unit of service entries in ARIES are validated with each monthly Payment Request and Performance Report, and also during annual site visit monitoring.

4) B. (1) Grantee Accountability Narrative

(a) Steps taken to implement National Monitoring Standards

The HRAU manager hired a temporary employee with expertise in audit and compliance monitoring to review internal subrecipient monitoring processes, conduct sample subrecipient

invoice verification and lead two training sessions, with a final report submitted on June 24 of this year. The Universal Standards, Part A Program Monitoring Standards, and Part A Fiscal Monitoring Standards were distributed to all current Part A-funded service providers. Additionally, all HRAU staff participated in the HRSA-sponsored Technical Assistance Webinar on *National Monitoring Standards for Part A Ryan White Grantees* held on September 15. The A/TCHHSD has hired an Internal Auditor, and recently added a Contract Compliance Unit in a Department-wide reorganization that becomes effective next month. Also next month, the Contract Compliance Manager is convening a special project workgroup to develop a contract monitoring and compliance manual for the department, with a goal of completion by early next year. An HRAU staff person has been assigned to this workgroup, in order to ensure that Ryan White Part A grant compliance issues are fully addressed. Medical Case Management and Non-Medical Case Management Program Monitoring Standards, Performance Measures/Methods, and Provider/Subgrantee Responsibilities were used this spring and summer in the development of Austin TGA's new Case Management Coordination Model. These have been incorporated into an RFP to be released in November. The Part A Program Monitoring Standards for all services currently are being used in updating and revising Standards of Care for all Austin TGA service categories.

(b) Process Used to Separately Track Formula, Supplemental, MAI, and Carry-Over Funds

The City of Austin Health and Human Services Department (City HHSD) accounting staff separately tracks formula and supplemental funds for Part A and MAI using the City's accounting system, Austin Integrated Management System (AIMS). The City Controller's Office is responsible for assigning a unique major program and program identifier number for each grant at the time of the grant budget set-up. All expenses for a particular program are posted at the program level. The budget profile includes: Fund Number, Department, Major Program, Program Number, and Program Period. Additionally, a distinctive task order number is created and set up to track grant personnel expenses for Administration, including HIV Planning Council, and for Quality Management. This allows for the tracking of formula and supplemental salary charges for each budget category. Salary expenditures are reported on a monthly accounting report. Each month, the City of Austin performs a month-end close of all expenses posted to AIMS. Departments are provided a detailed reporting of expenses posted by transaction at the program level. The monthly reports are reviewed by grant management and accounting staff prior to completion of the grant billing.

When the City's Purchasing Officer executes contracts, the contracted funds are individually encumbered and linked to the formula or supplemental fund number using the City's specific accounting profile. In addition, after contract execution, a document order is generated in lieu of a voucher, with a specific number that directly links the contract to the funding source. When a subcontractor's payment request is received, a unique number is assigned to the invoice in order to clearly link the payment request to the proper funding source.

(c) Timely monitoring and redistribution of unexpended funds

Contract monitoring staff meets monthly to review expenditures-to-date and determine whether unexpended funds need to be reallocated, in accord with HIV Planning Council's Rapid Reallocation Policy, to services that have demonstrated a need for additional funding. When indicated, contracts are amended and the funds redistributed in a timely manner.

(d-h) Fiscal and Program Monitoring Processes

Administrative Agency staff performs fiscal monitoring through monthly reviews of payment requests and expenditure patterns for each subcontractor. Staff also reviews each subcontractor's annual independent financial audit to obtain an overview of the agency's financial position. Provider site visits are performed at least annually to monitor fiscal management systems and document cost-effective performance. Staff reviews the agency's Board-approved financial policies and procedures, and ensures that subcontractors maintain an accounting system in accordance with Generally Accepted Accounting Principles (GAAP).

For FY 2010, fiscal monitoring visits to eight (8) subcontractors (100%) were completed by February 2011, with assistance provided by a temporary employee who was responsible for monitoring fiscal performance and practices of subcontractors. Per HRAU policy, a written report is issued to the subcontractor within 45 days following an on-site monitoring visit. When a fiscal-related concern is identified, the report describes the finding and/or observations and includes recommendations for corrective action. The subcontractor is given 30 days to submit a written response to the monitoring report and must include a plan for corrective action. The agency is given a specified time period to implement corrective action(s). Implementation of recommended corrective action(s) is verified with a follow-up site visit. Implementation of minor corrective action(s) identified in the plan is verified no later than the next annual fiscal review. To date, fiscal monitoring has not resulted in any findings.

Program monitoring is conducted annually to ensure that service providers have systems in place to deliver high quality services in compliance with contract terms and conditions. Of particular interest during site visits is the demonstration of how services complement primary medical care by facilitating access, encouraging adherence, and/or improving health outcomes. Programmatic reviews address the following areas: general program expectations, intake, demographic information, eligibility, income verification, validation of client-level data in AIDS Regional Information and Evaluation System (ARIES), retention in medical care, service plans, health education risk/reduction and treatment adherence, standards of care, and service coordination. Additionally, HRAU staff verifies compliance with Ryan White HIV/AIDS Program policies and HIV Planning Council directives.

Subcontractors are monitored to ensure compliance with program objectives including target populations, services provided, number of clients served, outcomes measured, and client-level data completeness and accuracy. During site visits, the monitoring team reviews client charts/files, interviews staff, and documents methods for collecting and reporting service outcomes. Monitors assess program operations through a review of program policies and procedures, standards of care, and the quality management plan. HRAU staff also review monthly and quarterly program performance reports and annual client satisfaction survey results.

Monitoring visits have been primarily focused on three areas: 1) reviewing client records and files; 2) assessing provider performance with respect to TGA-wide standards of care and adherence; and 3) validating service utilization and correct invoicing for services based upon client records and ARIES data. Observations and recommendations are discussed with subcontractors during exit interviews and cited in program monitoring reports, which are issued

within 45 days following a site visit. When a program-related concern is identified, the report describes the finding and/or observations and includes recommendations for corrective action. The subcontractor is given 30 days to respond in writing to the report with a corrective action plan that includes timelines. The implementation of recommended corrective action(s) is verified with a follow-up site visit. HRAU staff offers technical assistance as needed to assist subcontractors in complying with program and contract requirements. An agency's failure to implement corrective action can result in contract suspension or termination as specified in the contract. To date, program monitoring of FY 2011 Part A and MAI subcontractors has yielded no significant program compliance issues.

(i.) Number of Subcontractors Receiving Technical Assistance (TA) FY 2011 and Types of TA
The types and time frames of technical assistance provided by the Administrative Agency in FY 2011, and the number of subcontractors receiving assistance are as follows:
Medical Case Management System Development, one eight-hour session and one four-hour session (8); Cultural Competency, two eight-hour sessions (6); Developing a Quality Management Plan, three one-hour sessions (8); ARIES Data Entry Policies and Procedures, three two-hour sessions (3).

(j-k) OMB Circular A-133Audit Requirement
Subcontractors are required to arrange for an annual financial and compliance audit of funds received and performance rendered under their contract with the City of Austin in accordance with OMB Circular A-133. The annual independent audit must be submitted to the Administrative Agency within 120 days after the end of the subcontractor's fiscal year. In FY 2010 and FY 2011 to date, all subcontractors (100%) have demonstrated compliance with the audit requirement in OMB Circular A-133, and there were no findings. However, when there are findings, the Administrative Agency requires subcontractors to forward a copy of their corrective action plan and tracks plan progress during the following year.

(l-m) Process of receiving invoices and making payments
This process is described below under (2) Fiscal Staff Accountability.

(2) Fiscal Staff Accountability

Subcontractors submit monthly payment requests to their assigned contract manager who reviews required back-up documentation: the HIV Services Monthly Performance and Budget Status Report, and the ARIES Report which shows units of service delivered and numbers of unduplicated clients served for each service category. Following review and approval, the invoice is submitted to the City HHSD Accounting Unit for processing as described below.

Fiscal accountability for the Ryan White Part A grant is supported by the City HHSD Administrative Support Services Division. Key staff are shown in the shaded boxes linked to the Administrative Agency box on the Austin TGA Organizational Chart (Attachment 1). These positions are not funded by the Ryan White Part A grant, but they perform critical roles in ensuring fiscal oversight and control.

At the HRAU level, a Financial Specialist serves as Grants and Contracts Financial Coordinator. This position prepares and monitors staff salary allocations, and ensures staff charge time to correct task orders by reviewing timesheet reports and tracking task order balances on eCombs/DXR accounting systems expenditure reports. In addition, the position reviews grant expenditures weekly on Austin Integrated Management System (AIMS), and reviews DXR reports monthly and quarterly until closeout. Contract expenditures are monitored by reviewing Document Orders (DOs) on a monthly basis. Following receipt of the Notice of Grant Award, this position prepares a request for fund amendment in order to direct budget allocations. The process used to separately track formula, supplemental, unobligated balances, and carry-over funds is described above on page 43.

In the Administrative Support Services Division's Budget Unit, the Financial Consultant sets up the approved grant award on AIMS, including funding codes and personnel task orders, in close collaboration with the HRAU Financial Coordinator. This position also reviews and approves grant budget amendments. The Accounting Unit's Accounting Associate reviews and prepares payment transaction documents for subcontractors' grant-eligible, approved invoices received from HRAU Grants Coordinators. The Accounting Manager's responsibilities include:

- Review grant contract for financial reporting purposes;
- Review monthly grant billing documents (financial reports from AIMS, Journal Vouchers, Accounts Receivables, spreadsheets, etc.) completed by accountant;
- Review and approve online AIMS Journal Vouchers and Accounts Receivable Transactions;
- Review and verify reconciliation of grant fund;
- Review and approve grant financial reports (Vouchers, Financial Status Reports) per contract requirements;
- Review/approve online AIMS payment transactions of grant-eligible invoices/travel claims/mileage reports received from program;
- Review/perform accounting approval online (WORKS) of grant-eligible credit card purchases approved by HRAU; and
- Maintain grant financial records for auditing purposes (Grant and Annual Single Audit).

The Accounting Manger also submits the annual Part A Federal Financial Report (FFR).

4) C. Third Party Reimbursement

All clients seeking medical care services at David Powell Community Health Center (DPCHC) are screened for coverage by third party payers, including Medicaid, Medicare, Veterans benefits, private insurance, or other programs such as the Medical Assistance Program (MAP), a locally funded health care benefit program. DPCHC staff verifies Medicaid or Medicare coverage online through the Centers for Medicare and Medicaid Services (CMS) website or by using the Medicader software. Documentation of eligibility screening and coverage is maintained in individual client charts and/or electronic health records. Case managers assist clients in applying for SSI or SSDI, since they will be eligible for Medicaid if approved. When no coverage is available, the client is placed on a sliding fee scale based on current Federal Poverty Guidelines. An initial intake form is filed in the client's chart, along with a financial eligibility worksheet. During initial intake, clients sign a document that obligates them to update their financial and medical insurance coverage information at each follow-up visit or as

requested. Staff reviews the client's eligibility status, and the updated information is recorded on the financial worksheet. This screening process, which occurs at least twice within each program year, ensures financial and proof of status eligibility.

Through its contract language, the Administrative Agency requires that all accounting information and records are available for review. Moreover, contract language states:

> "CONTRACTOR agrees not to use funds provided under this Contract to pay for Medicaid/Medicare covered services for Medicaid/Medicare beneficiaries. The CONTRACTOR that provides Medicaid/Medicare-covered services shall be certified and provide documentation of certification to the CITY. The CONTRACTOR shall bill all eligible or available third-party payers before seeking reimbursement from Contract funds."

Program income is collected in the form of co-pays, co-insurance, clinic use fees, and reimbursement from third-party payers and is deposited into designated accounts and tracked using the providers' accounting system. Program income is reported and divided monthly on a proportional basis, then reinvested in each funding source's account so that all program income is expended before grant funds are utilized. Since the amount collected can fluctuate from month to month and year to year, program income is not budgeted but is utilized as collected to defray eligible program expenses such as laboratory tests and medications.

4) D. Administrative Assessment

(1)(a)(b) Planning Council assessment of the administrative mechanism

The Evaluations/Quality Management Committee of the HIV Planning Council was responsible for carrying out the administrative assessment process. During early spring of 2011, each provider received an electronic version of the survey, followed by a mailed self-addressed stamped envelope to return completed surveys. Seventy-five (75%) of surveys distributed were returned and analyzed by the Committee, with results reported to the full Planning Council.

Survey responses from funded service providers suggest there is an overall satisfaction level for activities such as timely payment reimbursements and data collection requests. Sixteen percent (16%) of respondents were very satisfied, fifty percent (50%) were satisfied, and thirty-three (33%) were neither satisfied nor dissatisfied. For contract renewals, survey respondents indicated an overall satisfaction level when asked about receipt of information to complete negotiation of a contract. Twenty-five percent (25%) were very satisfied, and seventy-five percent (75%) were satisfied with this activity. However, regarding negotiations for renewal of contracts, thirty-three percent (33%) of providers indicated they were dissatisfied with the time interval between notification of funding and execution of a contract. Half (50%) of respondents were satisfied, and sixteen percent (16%) were neither satisfied nor dissatisfied with this activity.

One recommendation for improvement was in reference to the timeliness of contract initiation. It was suggested that contract negotiation and submission of information be completed in advance of the start of the contract year, regardless of whether a Notice of Grant Award (NGA) had been received. The rationale was that aspects of service delivery outside of units/budgets

could be clarified in advance, such as changes in models or service delivery expectations. In order to facilitate timely contract execution, the Administrative Agent was successful in obtaining a Recommendation for City Council Action (RCA) to approve contract negotiations prior to receipt of the first FY 2011 Ryan White Part A NGA.

Other survey comments suggested that the timeframe between mid-year award notification and executed agreement is much too long. In response, the Administrative Agent has agreed to work more closely with funded providers by increasing the schedule of routine fiscal monitoring and reporting any outlying expenditure findings to the Planning Council on a monthly basis. Working collaboratively with Planning Council, the Administrative Agent has adopted a new system to routinely report service expenditure and utilization data. Reported on a monthly basis during every Planning Council business meeting, the source of information used to build a useful report for this system includes ARIES data, as well as some internal data sources which are gathered directly from the providers. The information is then entered into a format which displays inputs, outputs, and any extraneous variables that may affect the performance and expenditure data. A trend analysis is reported to the Planning Council on a monthly basis in order to assess that program funds are being disbursed in an efficient and effective manner.

Once a completed report is submitted by the Administrative Agent each month, the report is then vetted through three (3) committees of the Planning Council that work to decipher specific aspects of the report. The Allocations Committee focuses on actual spending trends and dollar amounts, while the Evaluations/Quality Management Committee reviews how services are being administered as demonstrated by findings noted in the Administrative Agent Report. Finally, the Needs Assessment Committee studies and discusses any service utilization issues that may be evident. This entire process is brought together by the Planning Council and allows a thorough assessment of the administrative mechanism in effectively and efficiently distributing program funds to areas of greatest need.

5) Planning and Resource Allocation

5) A. Letter of Assurance from Planning Council Chair

The Letter of Assurance from Planning Council Chair is in Attachment 2.

5) B. Description of Priority Setting and Resource Allocation Process

(a) How the needs of those persons not in care were considered

The Planning Council employed a systematic methodology to quantify and address the needs of persons not in care. The number of persons not in care was quantified utilizing demographic data from the Texas HIV/AIDS Reporting System (eHARS) and the AIDS Regional Information and Evaluation System (ARIES). Demographic data from the two reporting systems were compared using established "subtraction" methodology to present a demographic profile of persons not in care. To present a comprehensive picture, quantification included analysis of zip code and county specific data for the five-county TGA. A number of new ARIES data reports were produced to take full advantage of the data available. For example, the construct of age was sorted to further break down the 13–24 age group, revealing that the overwhelming majority of new HIV cases were found in young men ages 21–24 and, conversely, very few cases in ages 13–17. Additionally, ARIES reports were produced providing further detail regarding the utilization of Ryan White services across demographic profiles, including frequency of access to core medical care. These profiles provided a firm foundation for considering the needs of persons not in care during the priority setting and resource allocations process.

In addition to the data analysis described above, information also was garnered from a variety of other sources that were employed to elicit the needs of persons not in care. In February of this year, the Planning Council sponsored a city-wide symposium titled *State of the Epidemic* to facilitate community involvement and discussion regarding HIV/AIDS in the Austin TGA. The symposium afforded Planning Council the opportunity to engage the community in discussions regarding the needs of PLWH/A. Secondly, Planning Council participated in a series of public meetings to gather information in preparation for the Comprehensive HIV Services Plan. Focused meetings with service providers, the medical community, PLWH/A, and the community-at-large provided input from diverse segments. Comments from medical and service providers beyond Ryan White Part A/MAI providers (e.g., homeless services, private physicians, and clinics not funded by Ryan White) provided valuable insight into the needs of PLWH/A, including the scope and issues surrounding those persons not in care. Thirdly, a needs assessment survey was conducted by the University of Texas School of Social Work as part of the Comprehensive Needs Assessment Project. The survey included questions designed to discover the reasons why respondents were out of care. The Planning Council utilized the survey information in considering the needs of those out of care. Lastly, the membership of the Planning Council included members who lead service organizations delivering outreach, case management, and other services directly focused on engaging PLWH/A who are not in care. The Planning Council drew from this valuable experience and expertise when evaluating the needs of those out of care. Specifically, information was gained regarding outreach strategies that were proven successful in returning the out-of-care population to care. Awareness of strategies that

were less effective also provided value to the decision-making process regarding the out-of-care population.

(b) How the needs of those persons unaware of their HIV status were considered

Planning Council studied National, State, and local ARIES data in projecting the number of persons unaware of their HIV status. HIV case data trends for new cases over the last five years for the Austin TGA area provided validity for projections indicating that, in addition to the known HIV positive population, an additional 21% to 25% are unaware of their HIV status. The scope and demographic makeup of the unaware population was further validated by community and service provider input garnered from the symposium and community meetings referenced in (a) above. Planning Council membership included a member employed by the Austin/Travis County Health and Human Services Department Communicable Disease Unit, where local data are maintained for both confidential and anonymous testing. Based on his first-hand knowledge, the Planning Council was afforded access to HIV unaware data, as well as information on the challenges and successful strategies for reaching the unaware population. Additionally, a key objective outlined in the Comprehensive HIV Services Plan is to target at-risk populations that have a higher statistical probability of being HIV positive and unaware. The Planning Council carefully considered these data during the priority setting and allocations process in order to understand and address the needs of persons unaware of their HIV status.

HIV testing is considered a key method to identify individuals unaware of their status and ultimately get them into care in the Austin TGA. As active members of the Test Texas Coalition, an organization that advocates for routine HIV testing, the Planning Council is engaged in ongoing dialogue with the medical community in order to promote and encourage "opt-out" HIV testing. The Planning Council demonstrates their commitment to testing by making the topic a central focus during every community meeting and event as described in (a) above. The emphasis is primarily on reaching populations that do not frequent Ryan White Part A service providers.

(c) How the needs of historically underserved populations were considered

In order to provide the best possible demographic profile of underserved populations, an expanded set of ARIES reports was utilized as described in (a) above. The expanded data included additional MAI service reports. Demographic data on underserved populations, in conjunction with growth rates, provided a distinct profile of the underserved populations. Consistent with National trends, the data indicated that African American and Hispanic populations were the most underserved in the Austin TGA. Furthermore, these populations sought care later in the progression of the disease. Hispanics show the highest percentage progression from HIV to AIDS within one year of initial diagnosis.

In addition to analysis of data, the Planning Council considered input from the community gained from the meetings and community events described above, and input from Planning Council members and community leaders who worked directly with minority and underserved populations. Input was garnered from ministers of predominately African American churches who had first-hand knowledge of how to best reach the underserved within their community.

These findings were considered by the Planning Council during the priority setting and resource allocations process, particularly in MAI planning and allocations.

(d) How PLWH/A were involved in the priority setting and allocation process and how their priorities are considered in the process

Planning Council membership consistently exceeded the HRSA requirement that at least one-third of the members be PLWH/A. Current membership has an adequate number of consumers who are represented on all five (5) committees. Three (3) of the five (5) committees are chaired by a PLWH/A. The representation of PLWH/A on the Planning Council and in key leadership positions ensures that the Planning Council maintains a constant focus on the needs and perspectives of PLWH/A. Moreover, Planning Council meetings are frequently attended by members of the community, including organizations such as Women's Rising. Citizens who frequently attend Planning Council meetings include PLWH/A, and these citizens share their thoughts and perspectives with the Planning Council through many mediums including letters, e-mails, and the open communications portion of the meetings. In addition, support of the Needs Assessment Project Survey and Client Satisfaction Survey demonstrate ongoing efforts by the Planning Council to seek input from PLWH/A, and to actively engage them in the decision-making process.

(e) How data were used in the priority setting and allocation process to increase access to core medical services and reduce disparities in access to the continuum of HIV/AIDS care in the TGA

The Planning Council analyzed data from the Texas HIV/AIDS Reporting System (eHARS) and ARIES. It also considered information from consumer surveys that quantified persons receiving core medical services. The goal was to create a profile of those out of care. A new ARIES report was created showing the frequency of medical care and the time frame when consumers deemed out of care last received care. Also considered were reports showing the demographic profile of consumers accessing core services by service type. These data were all considered by the Planning Council during the priority setting and allocations process. Additionally, findings and recommendations presented by the Clinical Quality Management (CQM) Committee's new Case Management Model lead to Planning Council's vote to fund a Case Management Model pilot project, with the expectation that new case management strategies will increase the number of PLWH/A who consistently access care.

(f) How changes and trends in HIV/AIDS epidemiology data were used in the priority setting and allocation process

The expanded ARIES data reports and the Epidemiologic Profile produced by the Texas Department of State Health Services (DSHS) were carefully reviewed to evaluate the status of the epidemic and trends indicated by the data. Expanded ARIES data included additional demographic and geographic analysis within the Austin TGA, in an effort to identify populations and areas that required additional focus. These data have been relatively consistent in recent years, with the number of new cases holding relatively steady and the overall growth in the number of PLWH/A increasing as antiretroviral medications impact the longevity of PLWH/A and the aging of the population.

Epidemiological data continue to demonstrate that minority populations are underserved. Particularly, the data indicate that the African American population continues to experience a disproportional burden in terms of the number of cases relative to the population. These data also continue to support the need for outreach to the MSM population, as this group continues to constitute the largest percentage of PLWH/A and those most at risk. The Planning Council also carefully monitors trends at the remote county level, where the relatively small numbers of PLWH/A who live outside Travis County can fluctuate significantly from year to year. What is clear from geographic data is that the population of PLWH/A is growing in Williamson County, thereby necessitating additional service provider resources in that area. As a result of the trends indicated by epidemiological data and information from other sources, funding was increased for non-medical case management and MAI Tier 2 non-medical management, with a continued focus on Psychosocial Support Services groups in the suburban and rural areas.

(g) How cost data were used by the Planning Council in making funding allocation decisions

The Planning Council evaluated ARIES cost reports in preparation for allocation decisions. ARIES reports were enhanced to add additional data sorts, including costs per unit, average costs per consumer, and distribution of costs relative to demographics. Service categories that were under-spent received particular attention in order to determine the underlying reason(s) that all funds were not utilized. This is an essential determination, since an erroneous conclusion that demand for the service is low and that funding is not needed could negatively impact consumers relying on that service. A number of contributing factors were identified, including the fact that a physician vacancy at the Outpatient/Ambulatory Medical Care (OAMC) service provider resulted in unspent OAMC funds. Also considered was the impact of late grant award notifications and the subsequent administrative time required to get contracts in place. For those services that received supplemental allocations, the viability of requiring a service provider to put staff and infrastructure in place to quickly utilize reallocated funds was also considered from the perspective of outcomes. To supplement the Planning Council's knowledge and understanding of Ryan White services and the challenges and issues faced by service providers in delivery of service, the Planning Council requested service providers to conduct formal presentations on specific services. This information enabled the Planning Council to more fully understand how funds were expended in the previous grant period and the performance outcomes related to those expenditures.

(h) How unmet need data were used by the Planning Council in making priority and allocation decisions

Unmet need was quantified utilizing demographic data from Texas eHARS and ARIES. Demographic data from the two reporting systems were compared using established "subtraction" methodology to quantify and present a demographic profile of persons with unmet need. Data from consumer surveys and data provided by service provider presentations were used to profile those PLWH/A with unmet need and the reason(s) why a person's needs were unmet. By identifying the barriers to care, Planning Council was able to assess which barriers could be directly reduced by redirecting service category resources, and which barriers are best addressed through psychosocial case management.

(i) How the Planning Council's process will prospectively address any funding increases or decreases in Part A award

The Planning Council developed the FY 2012 Allocations Plan with the assumption of level funding. The Planning Council also developed prospective contingency plans for funding increases or decreases to the Part A and MAI awards. The strategy for the increase and decrease plans remains focused on ensuring that adequate funding is directed to core services and that specified service categories will not fall below a minimum level, regardless of grant award amount. This strategy ensures that core services remain the primary focus of allocations and that services deemed most essential are funded at a level that ensures the service is viable from a service delivery and performance outcome standpoint. The grant award increase and decrease plan was approved by a Planning Council vote.

(j) How MAI funding was considered during the planning process to enhance services to minority populations

As described above, the Planning Council utilized demographic data and community input in assessment of the needs of minority populations. Data clearly indicate that African American and Hispanic populations shoulder a disproportionate burden with respect to HIV. The data also indicate these two populations are underserved and tend to begin care later in the progression of the disease, thus validating the Austin TGA's existing MAI target populations. African American and Hispanic PLWH/A require continued MAI funding and concentrated focus in order to adequately meet their needs. The Planning Council increased allocations for MAI medical and non-medical case management for the current grant period in recognition of the demonstrated need for those services. Performance criteria for outreach services were also reviewed to ensure that performance-based measures would fulfill goals outlined in the Comprehensive HIV Services Plan.

(k) How data related to Persons Unaware of HIV Status was used in the Priority and Allocations decision making process

Surveillance and epidemiological data from Texas DSHS were used in conjunction with data and estimates from the Centers for Disease Control and Prevention (CDU) to quantify the number of PLWH/A. The goal also was to develop a demographic profile of persons living in the Austin TGA who are unaware of their HIV status. While the DSHS data for 2010 indicated a small decline in the number of PLWH/A, the State explained that the migration to an electronic reporting system (eHARS) enabled an elimination of duplicated records that were included in previous reports. Finally, under the auspices of the Planning Council, a new EIIHA Collaborative consisting of community and service providers dedicated to working with the HIV unaware and out-of-care populations will further explore variables that are most effective in helping people become aware of their HIV status and remain in care. As the EIIHA Collaborative researches and deliberates, information will be funneled to the Planning Council in order to incorporate findings related to persons unaware of their HIV status into the priority setting and allocations decision-making process.

6) B. Maintenance of Effort

TGA: Austin, Texas Prepared by: Carmen Chronis, Financial Specialist		Report for FY 2009 and FY 2010 Telephone: (512) 972-5078	
Item No.	**Agency/Department/Other Unit of Government**	**FY 2009 Amount**	**FY 2010 Amount**
1	Austin Health and Human Services Department Communicable Disease HIV Education and Outreach Program Fund 1000-9100-3030	$292,944.15	$405,078.30
2	Austin Health and Human Services Department (HHSD) HIV Social Services Contracts with CBOs Fund 1000-4700-6161, 6162 and 6163	$592,483.27	$673,179.00
3	Travis County HIV Social Services Contracts CBOs Dept. 58 – Div. 91	$467,068.60	$464,501.01
4	Travis County Health Care District (TCHD) David Powell Community Health Center (DPCHC) Fund 7THD-952-3033 and Community Care TX	$29,490.35	$0
5	Travis County Health Care District (TCHD) David Powell Community Health Center (DPCHC) Fund 7THD-952-3034 and Community Care TX	$516,399.84	$0
6	Travis County Health Care District (TCHD) David Powell Community Health Center (DPCHC) Fund - Community Care	$311,582.20	$1,103,649,74
	TOTALS	**$2,209,968.41**	**$2,646,408.05**

Austin HHSD uses the City of Austin accounting system, Austin Integrated Management System (AIMS), and a segmented chart of accounts to capture and monitor budget and expenditures. The main components of the chart of accounts are the fund, department and unit codes (FDU). Digital Express Reports (DXR) is used to view financial reports, which are produced using AIMS. Expenditures related to HIV/AIDS core medical and support services, as well as prevention services, have coding (FDU) and are tracked on a monthly basis. The TCHD CommUnityCare's accounting system, Sage MIP, uses a segmented chart of accounts to capture expenditures. One segment in the chart of accounts discerns the location within the network to which each transaction pertains. The only services provided at DPCHC are those related to the primary medical care of persons living with HIV/AIDS. Travis County uses the Sungard accounting system, a segmented chart of accounts that captures and monitors budget and expenditures. The components of the chart of accounts are the fund number, department/division numbers, activity/subactivity codes, and element and object numbers. Financial reports can be obtained from the system using the fourteen digit line item numbers. Expenditures for the HIV social services contracts are separated by using commodity subcommodity codes for HIV programs specified in the contract.

7) Clinical Quality Management

7) A. (1) Description of Overall Clinical Quality Management Program

(a) CQM structure, vision/mission and goals

The overall purpose and goals of the Austin TGA Clinical Quality Management (CQM) Program are: to ensure HIV medical services are provided to patients consistent with the most recent Public Health Service (PHS) guidelines for the treatment of HIV disease and related opportunistic infections; to continuously improve clinical practice standards for vital health related supportive services; and to ensure that these supportive services enhance client linkages to HIV medical care and positive health outcomes. The Quality Model used throughout the Austin TGA is the PDSA model (Plan, Do, Study, Act).

The Administrative Agency's CQM Coordinator is responsible for implementing the CQM Program. The CQM Coordinator works under the direction of the HIV Resources Administration Unit Manager who is responsible for the overall administration of the Ryan White Program. Five percent (5%) of the Ryan White Part A grant award supports the CQM program, including salaries or portions of salaries for the CQM Coordinator, Data Manager, Health Planner and Manager (1.9 FTEs total) as well as related program support expenses. Currently, no entities are under contract for CQM activities, reporting, data collection and /or training. However, prior to the end of FY 2011, the grantee plans to contract with external entities for cultural competency training and to evaluate the extent to which primary medical and oral health services adhere to HIV PHS treatment guidelines.

(b) Established Quality Management Program

The CQM Coordinator is responsible for facilitating activities related to the design, implementation, and revision of the CQM Plan, selecting project-specific continuous quality improvement outcomes, developing Requests for Proposals (RFPs) for specialized reviews, initiating a system to measure client satisfaction, establishing and maintaining a Continuous Quality Improvement (CQI) Committee and developing and implementing service-specific standards of care for funded service categories. The CQM Coordinator conducts client chart audits to ensure adherence to established PHS treatment guidelines, analyzes clinical and service utilization data, ensures target outcomes are achieved, develops quality improvement plans with health service providers, and monitors progress in implementing improvement strategies.

The Data Manager and Health Planner collaborate with the CQM Coordinator to ensure data integrity, analyze data, and develop reports on client demographics and service utilization trends. QM staff also develops health outcome indicators and methods for collecting and analyzing health outcome data, conducts program monitoring, and analyzes client satisfaction and chart review data for use in developing service improvement plans. The CQM staff review all RFPs and contracts to ensure CQM requirements are addressed including contractor grievance policies and procedures, standards of care, CQM plans, cultural competency, client satisfaction, and adherence to data collection requirements.

The CQI Committee and/or its working subcommittees meet at a minimum bi-monthly. Membership consists of the CQM Coordinator, Parts A and C sub-grantee representatives, social workers and clinicians or representatives of clinicians, one consumer, at least one Planning Council member, and the Part B Planner/quality program representative. The CQI Committee provides input and direction to the Austin TGA CQM Program. The Committee is involved in determining CQM Program priorities, establishing and reviewing health outcome indicators, assessing performance measures, making recommendations for performance improvement, and reviewing and updating the CQM Plan. Additionally, the CQI Committee provides input into the development of quality improvement tools, (e.g., client satisfaction surveys, client grievance policies, case management acuity, client eligibility by service category, and standards of care). The CQI Committee reports cumulative service outcome results to the Planning Council.

Consumers are involved in the CQM program through their participation on the CQI Committee, through their input on client satisfaction surveys, and participation in focus groups. There is currently one consumer member of the CQI Committee; active recruitment of consumers continues.

The CQM program is assessed annually by grantee staff and periodically by an outside consultant. The HIV Resources Administration Unit Program Manager assesses the program via a review of annual goals and objectives. Feedback is provided to the CQM Coordinator and adjustments are incorporated into the program/CQM Plan for the upcoming year. The process for providing feedback and implementing changes is continuous among the CQM program staff and the Ryan White Part A funded providers. The CQM staff also offer technical assistance to providers in the following areas: collecting and reporting of client-level data, standards of care implementation, CQM plan development, use of CQI tools, and data interpretation. A more extensive Technical Assistance (TA) effort is underway in medical case management and modeling. The CQM Coordinator conducts a CQI Committee review of the CQM program annually. As needed, program changes are implemented through performance improvement plans and contract amendments.

All Ryan White providers are required to have a CQM plan and to evaluate their program's performance in meeting their CQM goals and standards of care by analyzing results from output and outcome data, client satisfaction surveys, and client chart reviews. The David Powell Community Health Center (DPCHC) provides ambulatory outpatient medical care and is a part of the Federally Qualified Health Center (FQHC) network. DPCHC is required to perform regular chart audits and quality control reviews as set out in the FQHC Quality Management/Risk Management Plan. Additionally, chart audits are conducted by the CQM Coordinator and/or other external reviewers to ensure compliance with DHHS treatment guidelines and standards of care. This plan addresses quality management and improvements across all services provided within the FQHC network including medical care, behavioral health, medical case management, pharmacy, and safety and risk management. Results of the CQI activities are presented through a chain of command, including the FQHC Board of Directors. Any adverse findings result in the creation of an immediate improvement plan.

The indicators and current results for primary medical care and medical case management services are listed below. Each indicator is measured against a benchmark or target developed by the Administrative Agency with input from services providers, the Clinical Quality Improvement Committee and the Planning Council.

Table A: Outpatient/Ambulatory Medical Care and Medical Case Management Indicators

Outpatient/Ambulatory Medical Care Indicators	Results – Part A Clinic (DPCHC)
1. 90% of clients with CDC-Defined AIDS will be prescribed an antiretroviral therapy (ART) regimen during the measurement year. Excluded patients newly enrolled in care during last three months of the measurement year.	**98%** of clients with CDC-Defined AIDS were prescribed an antiretroviral therapy (ART) regimen during measurement year.
2. 95% of clients with an HIV infection and a CD4 T-Cell count < 200 cells/mm^3 will be prescribed PCP prophylaxis during the fiscal year. Excluded are patients with CD4 T-Cell count < 200 cells/mm^3 repeated within three months rose above 200 cells/mm^3 and patients newly enrolled in care during last three months of the measurement year.	**94%** of clients with an HIV infection and a CD4 T-Cell count <200 cells/mm^3 were prescribed PCP prophylaxis during the fiscal year.
3. 90% of clients with an HIV infection will have 2 or more CD4 T-Cell counts performed during the fiscal year. Excluded are patients newly enrolled in care during last six months of the measurement year.	**85%** of clients with an HIV infection had 2 or more CD4 T-Cell counts performed during the fiscal year.
4. 80% of clients with an HIV-infection will have two or more medical visits during the measurement year. Excluded are patients newly enrolled in care during the last six months of the measurement year.	**84%** of clients with an HIV-infection will had two or more medical visits during the measurement year.
5. 100% of pregnant women with an HIV infection will be prescribed antiretroviral therapy during the measurement year. Excluded are patients whose pregnancy is terminated, and pregnant patients who are in the 1st trimester and newly enrolled in care during the last three months of the measurement year.	**100%** of pregnant women with an HIV infection were prescribed antiretroviral therapy during the measurement year.
Medical Case Management Indicators	**Results**
80% of clients surveyed will report satisfaction with services provided	**89%** of clients responding to the FY10 survey who received medical case management rated these services above average or better ("good" or "excellent"). Results for FY11 are still being compiled and are expected to be available by mid-December 2011.
75% of clients receiving medical case management services will keep at least two subsequent medical provider visits over the course of the measurement year. Excluded are patients newly enrolled in care during the last three months of the measurement year.	**89%** of medical case management clients (those who were not newly enrolled during the last 3 months of the measurement year) received at least two medical provider visits over the course of the measurement year.

Source: *ARIES and Austin TGA Client Satisfaction Survey*

7) B. Description of Data Collection and Results

(1-5) Client level data capabilities, system, and processes

The Administrative Agency's CQM staff use several methods to collect client level outcome data and related information on program progress in meeting the goals and objectives outlined in the CQI Plan. Methods include: 1) contract compliance site audits; 2) client satisfaction surveys; 3) formal chart reviews; and 4) the AIDS Regional Information and Evaluation System (ARIES).

The Austin TGA utilizes ARIES to administer its data management program. The system enhances services for clients with HIV by helping providers automate, plan, manage, and report on client level data. This web-based, Ryan White Services-compliant database is used in the states of California, Nevada, and by all Ryan White Parts A and B grantees in Texas. The Texas Department of State Health Services (DSHS) manages ARIES in Texas. The system is designed to collect a wealth of demographic, clinical, and service encounter information on both HIV infected and affected clients. Examples of this data include but are not limited to: race, ethnicity, date of birth, gender, city, county and state of residence, ZIP code, living situation history, poverty level, insurance, disease stage, risk factors, CD4s, viral loads, sexually transmitted infections (STI), hepatitis, tuberculosis including multi-drug resistant TB, immunizations, ART therapy, and anti-retroviral medications taken. For calendar year 2010, ARIES contains information on approximately 2,835 unduplicated clients.

Data management policies, contract language, periodic desktop data monitorings, and team site visits help ensure the quality of client level data submitted to HRSA. For the 2009 and 2010 submission cycles, training was made available to all providers, as well as an overview for administrative agency staff. Written documentation was developed specifically for Austin TGA providers using HRSA developed training documents as templates. Administrative agency grant coordinators, quality management coordinator, planner, and program manager review and validate each agency's RSR prior to final submission. Processes to improve clinic outcomes are discussed below.

(6) How Data Has Been Used to Improve or Change Service Delivery in Austin TGA

The CQM Program has been successful in improving the quality of services to HIV positive clients in the Austin TGA by bringing all Ryan White providers together to collaborate on improving services to clients and developing quality tools to provide uniformity and consistency. The following activities have resulted in improvements or changes in service delivery:

1. In a health literacy project, the ARIES client consent form that allows providers to share client data was reviewed to assess a client's ability to understand the consent form and to make appropriate decisions. As a result, a brochure was developed in English and Spanish that explained the information in the consent form that was more understandable to clients entering the care system.
2. The CQI Committee has ad hoc subcommittees to address targeted quality issues as needed to facilitate completion of the PDSA cycle. This year focused on the following:
   a. The Medical Case Management Subcommittee reviewed medical case management models and standards. A HRSA consultant was requested and identified to assist with development of an integrated medical and non-medical case management service model. The transition plan was developed by a stakeholder workgroup consisting of CQM staff,

providers, Planning Council and consumer representatives. Goals for the 2012 grant year include piloting the new case management model of care, revising standards of care, and improving client intake processes.

b. Through a collaborative effort between the providers, HIV Planning Council, and our Quality Management Coordinator, the client satisfaction survey tool was updated during the measurement year. The goal of this process was to address the need to simplify the tool, enhance the quality of the data received, and improve the ability to compare results over multiple grant years. Due to the length of this process and the number of stakeholders involved, the surveys were administered during August and September of 2011. Responses were based on a Likert scale, with 1 being the lowest in satisfaction or agreement and a 5 being the highest in satisfaction and agreement. In addition, demographic information was collected, including but not limited to race/ethnicity, age, ZIP code, gender, and sexual orientation. Nearly 600 clients completed surveys. Currently, the survey results are being compiled for analysis and reporting in SPSS® and this process should be completed in November 2011. Based on the surveys already received, it appears that the results will be very helpful and that the tool can be used in subsequent survey periods with very few modifications, if any.
c. The Return to/Retention in Care (RTC) Subcommittee was originally formed in September 2009, to focus on the return of clients to care who were previously in care or who were at risk of falling out of care. The Subcommittee has tracked 760 clients.

Table B: Return to Care Outcomes; 760 Clients tracked between 2009 and 2011

186 (24%)	Scheduled for medical appointments
2	Declined appointments.
102 (13%)	Discharged
1	Referred to Minority AIDS Initiative (MAI) program
37 (5%)	Incarcerated
144 (19%)	Relocated
115 (15%)	Transferred
74 (10%)	Message left
93 (12%)	Unable to contact

Source: *Austin TGA Return to Care Collaborative Two-Year Update, David Powell Community Health Center, 2011*

The RTC Subcommittee reported that the increased communication with David Powell Community Health Center regarding clients' medical treatment improved case management planning. Needs identified include but are not limited to increased referrals to case management and the need for a centralized system for case management agencies to share capacity. The RTC Subcommittee also initiated a QI project to increase the number of women who receive annual pelvic exams. Several RTC partners have added medical updates to their case management plans that include women's health screenings. Future projects include increased tracking of client share rates in ARIES and developing strategies to increase sharing to facilitate care coordination.

The Administrative Agency provides data reports to the Planning Council on a monthly and quarterly basis. These reports include service utilization data from ARIES, results from the Retention in Care Collaborative, and epidemiological data from the state of Texas and CDC. Results from the Client Satisfaction Survey also are reviewed along with the Needs Assessment update, and findings from fiscal and program monitoring reports.

BUDGET INFORMATION - Non-Construction Programs

OMB Number: 4040-0006
Expiration Date: 06/30/2014

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. Administration	93.914	$ 414,116.00	$	$	$	$ 414,116.00
2. Quality Management	93.914	207,058.00				207,058.00
3. Direct Services	93.914	3,519,995.00				3,519,995.00
4. MAI	93.914	258,872.00				258,872.00
5. Totals		$ 4,400,041.00	$	$	$	$ 4,400,041.00

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY (1) Administration	(2) Quality Management	(3) Direct Services	(4) MAI	Total (5)
a. Personnel	$ 260,230.00	$ 131,270.00	$	$ 28,073.00	$ 419,573.00
b. Fringe Benefits	120,041.00	54,436.00		10,295.00	184,772.00
c. Travel	14,550.00	5,100.00		464.00	20,114.00
d. Equipment	4,380.00	0.00		0.00	4,380.00
e. Supplies	7,916.00	1,000.00		0.00	8,916.00
f. Contractual	1,500.00	12,452.00	3,494,995.00	220,040.00	3,728,987.00
g. Construction	0.00	0.00		0.00	
h. Other	5,499.00	2,800.00	25,000.00		33,299.00
i. Total Direct Charges (sum of 6a-6h)	414,116.00	207,058.00	3,519,995.00	258,872.00	$ 4,400,041.00
j. Indirect Charges					$
k. TOTALS (sum of 6i and 6j)	$ 414,116.00	$ 207,058.00	$ 3,519,995.00	$ 258,872.00	$ 4,400,041.00
7. Program Income	$	$	$	$	$

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e)TOTALS
8. Quality Management	$	$	$	$
9. Direct Services				
10. MAI				
11.				
12. TOTAL (sum of lines 8-11)	$	$	$	$

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$	$	$	$	$
14. Non-Federal	$				
15. TOTAL (sum of lines 13 and 14)	$	$	$	$	$

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (YEARS) (b)First	(c) Second	(d) Third	(e) Fourth
16. Administration	$ 414,116.00	$ 414,116.00	$ 414,116.00	$ 414,116.00
17. Quality Management	207,058.00	207,058.00	207,058.00	207,058.00
18. Direct Services	3,519,995.00	3,519,995.00	3,519,995.00	3,519,995.00
19. MAI	258,872.00	258,872.00	258,872.00	258,872.00
20. TOTAL (sum of lines 16 - 19)	$ 4,400,041.00	$ 4,400,041.00	$ 4,400,041.00	$ 4,400,041.00

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:

22. Indirect Charges:

23. Remarks:

Budget Narrative File(s)

*** Mandatory Budget Narrative Filename:** BudgetNarrativeLineItemFY12.pdf

Add Mandatory Budget Narrative | Delete Mandatory Budget Narrative | View Mandatory Budget Narrative

To add more Budget Narrative attachments, please use the attachment buttons below.

Add Optional Budget Narrative | Delete Optional Budget Narrative | View Optional Budget Narrative

FY 2012 Ryan White Part A Budget Justification Narrative

A. Personnel **$419,573**

Administration *$260,230*

- Manager (G. Bolds, $74,922 x 0.10 FTE = $7,492). Responsible for the overall administration of Ryan White Part A program activities. Oversees and manages staff to ensure grant requirements are met; oversees data and quality management activities to ensure adherence to established policies.
- Grant Coordinator (B. Mendiola, $55,947 x 0.50 FTE = $27,973). Responsible for the coordination and preparation of the Part A grant application and preparation of grant related post-award reports. Coordinates the subcontracting process by preparing and processing RFAs. Prepares and negotiates grant subcontracts; assures compliance with by monitoring subcontracts; processes payment requests and monitors contract expenses.
- Grant Coordinator (H. Beck, $57,432 x 0.40 FTE = $22,973). Prepares and negotiates grant subcontracts; assures compliance with conditions of grant by monitoring subcontracts; processes payment requests and monitors and analyzes contract expenses including administrative caps, program income, payer of last resort, and service charges
- Grant Coordinator (D. Garza, $58,917 x 0.35 FTE = $20,621). Prepares and negotiates grant subcontracts; assures compliance with conditions of grant by monitoring subcontracts; processes payment requests and monitors and analyzes contract expenses.
- Financial Specialist (C. Chronis, $54,695 x 0.40 FTE = $21,878). Responsible for administrative and fiscal aspects of the grant. Prepares grant application budget documents, develops final program budgets and monitors grant and contract expenditures. Compiles financial reports as needed to analyze grant and contract expenditures; coordinates grant close-out activities ensuring reports are submitted to HRSA, including end of year MOE reports.
- Planner II (Vacant, $66,703 x 0.15 FTE = $10,005). Research core medical and support services information and provide data for HIV Planning Council to support planning activities; develops and analyzes performance measures and service utilization data.
- Data Manager (C. Manor, $54,652 x 0.10 FTE = $5,465). Responsible for all aspects of maintaining the HIV services client-level data collection system. Collects and analyzes data, and submits reports to HRSA, HIV Planning Council, and HIV Unit Manager.
- Planning Council Community Services Program Manager (K. Pemberton, $61,526 x 1.0 FTE). Coordinates and supervise various aspects of the Planning Council's activities and mandated functions. Facilitates and ensures Planning Council processes adhere to federal, state and local laws. Supervise support staff.
- Planning Council Planner II (Vacant, $53,040 x 1.00 FTE). Assist the HIV Planning Council Manager in all aspects of supporting the Planning Council. Supports the Need Assessment and Comprehensive Planning committees. Provides research and data collection in support of the Council priority settings and allocation process.
- Planning Council Administrative Senior (K. Carlyle, $29,257 x 1.0 FTE). Assists the HIV Planning Council Coordinator to prepare Planning Council meeting agendas and supporting documents for approximately 25 meetings annually.

Administration MAI *$18,312*

- Grant Coordinator (H. Beck, $57,432 x 0.08 FTE = $4,595). Prepares and negotiates MAI grant subcontracts; assures compliance with conditions of grant by monitoring subcontracts; processes payment requests and monitors and analyzes contract expenses.

- Grant Coordinator (D. Garza, $58,917 x 0.14 FTE = $8,248). Prepares and negotiates MAI grant subcontracts; assures compliance with conditions of grant by monitoring subcontracts; processes payment requests and monitors and analyzes contract expenses.
- Financial Specialist (C. Chronis, $54,695 x 0.10 FTE = $5,469). Responsible for overall administrative and fiscal aspects of the grant. Prepares grant application budget documents, develops program budgets and monitors grant and contract expenditures. Prepares financial reports as needed to analyze grant and contract expenditures; grant close-out activities ensuring reports are submitted to HRSA, including MOE.

Quality Management *$131,270*

- Program Manager (G. Bolds, $74,922 x 0.15 FTE = $11,238). Responsible for the overall administration of Ryan White Part A quality management program. Supervises staff to ensure grant requirements are met and quality program procedures are followed; meets with subcontractors regarding TGA quality improvement issues; ensures adherence to established QM program policies.
- Quality Management Coordinator (Vacant, $74,192 x 0.80 FTE = $59,354). Coordinates Quality Management activities, including establishing and implementing a clinical quality management plan; ensures service provided by Part A funds adhere to Public Health Service treatment guidelines and established standards of care.
- Planner II (Vacant, $66,703 x 0.50 FTE = $33,352). Research information and data as requested or needed for QM planning; analyzes service utilization data, works in collaboration with QM coordinator in developing measures including implementing HRSA core clinical performance measures; tracks service utilization trends.
- Data Manager (C. Manor, $54,652 x 0.50 = $27,326). Responsible for all aspects of maintaining a HIV services client-level data system that supports the QM program. Collects and processes QM data, e.g. client satisfaction survey and health indicator data; prepares and submits reports to HRSA, HIV Planning Council, and HIV Unit Manager.

Quality Management MAI *$9,761*

- Quality Management Coordinator (Vacant, $74,192 x 0.08 FTE = $5,935). Coordinates Quality Management activities, including establishing and implementing a clinical quality management plan; ensures service provided by Part A funds adhere to Public Health Service treatment guidelines and establishes/updates standards of care.
- Data Manager (C. Manor, $54,652 x 0.07 = $3,826). Responsible for all aspects of maintaining a HIV services client-level data system that supports the QM program. Collects and processes QM data, e.g. client satisfaction survey and health indicator data; prepares and submits reports to HRSA, HIV Planning Council, and HIV Unit Manager.

B. Fringe Benefits **$184,772**

Fringe Benefits are calculated at various rates. This includes FICA at 6.2%, Medicare at 1.45% Retirement at 16% per 7 months and 18% per 5 months, Health Care Benefits at $10,239 per FTE for 7 months and $11,263 for 5 months due to fiscal year transition per 7.42 FTE. Incentive Pay for 3.00 FTE.

- Total Administration $120,041
- Total Administration MAI $7,191
- Quality Management $54,436
- Quality Management MAI $3,104

C. Travel **$20,114**

Administration Local Travel: *$1,050*

- Grantee: Staff travel in local TGA to perform monitoring activities, attend meetings and coordinate grant activities approximately 946 miles x 0.555 = $525.
- Planning Council: PC member's mileage to attend Planning Council meetings/functions approximately 946 miles x 0.555 = $525.

Administration Local Travel MAI: *$385*

- Grantee: Staff travel in local TGA to perform monitoring activities, attend meetings and coordinate grant activities approximately 694 miles x 0.555 = $385.

Quality Management Local Travel: *$800*

- QM staff travel in local TGA to perform QM activities, attend meetings and coordinate QM program activities approximately 1,442 miles x 0.555 = $800.

Quality Management Local Travel MAI: *$79*

- Staff travel in local TGA to perform QM activities, attend meetings and coordinate QM program activities approximately 143 miles x 0.555 = $79.

Administration Out Of Town Travel: *$13,500*

- Grantee: Attend three quarterly EMA/TGA meetings. Includes, lodging, meals, and travel related expenses for three (3) persons from the Administrative Agency at $3,500.
- Grantee: Attend HRSA sponsored All grantees meeting. Includes airfare, lodging, meals, and travel related expenses for three (3) persons from the Administrative Agency at $1,800 per person =$5,400.
- Planning Council: Attend 3 quarterly EMA/TGA meeting. Includes, lodging, meals, and travel related expenses for one (1) Planning Council representative at $1,000.
- Planning Council: Attend HRSA sponsored All grantees meeting. Includes airfare, lodging, meals, and travel related expenses for two (2) persons from Planning Council at $1,800 per person =$3,600.

Quality Management Out Of Town Travel: *$4,300*

- One QM person attending two Texas EMA/TGA & Part B meetings. Attend the annual Institute of Health Care Improvement meeting. Includes, lodging, meals, and travel related expenses at $2,500.
- One QM person attending HRSA sponsored All Grantees meeting. Includes airfare, lodging, meals, and travel related expenses for one (1) person at $1,800 per person.

D. Equipment **$4,380**

Administration: $800

- Grantee: Computer purchase to replace obsolete ones $800
- Planning Council: Computer software upgrades $300
- Planning Council: Rental of copier equipment to reproduce PC meeting materials $3,280

E. Supplies **$8,916**

Administration: *$7,916*

Grantee: $1,551

- Postage for subcontractor's contracts and correspondence $175
- Office furniture, to purchase or replace office chairs $300
- Micro Projector for meetings and presentations for staff and providers $435
- Office supplies, usual and customary, each less than $100. $641

Planning Council: $6,366

- Food and beverages for Planning Council members when HIV Planning Council and committee meetings extend through meal time. $4,500

- Postage for meeting minutes and announcements. $125
- Office furniture, to purchase or replace office chairs $350
- Telephone basic system including equipment and calling charges. $750
- Office supplies, usual and customary, each less than $100. $641

Quality Management: *$1,000*

- Office supplies, usual and customary, each less than $100. $1,000

F. Contractual **$3,728,987**

HIV Services *$3,494,994*

Service contracts with local non-profit organizations for an array core medical and support services for $3,494,994.

HIV Services MAI *$220,040*

Service contracts with local non-profit organizations for MAI services for $220,040.

Administration *$1,500*

- Planning Council: subcontract for Parliamentarian services. $1,500.

Quality Management: *$12,452*

- Professional consultants to train providers in skills and knowledge needed to improve health outcomes, e.g. motivational interviewing, and adherence counseling. $4,000.
- Training to enhance skills and knowledge of case managers working with PLWHA in the areas of substance abuse and mental health issues. $3,400
- Specialized Quality Review of medical care, case management, substance abuse and mental health providers within the TGA. $5,052

G. Construction **$0**

H. Other **$33,299**

Administration *$5,499*

Grantee: *$3,750*

- Advertising of Public Notices for Request for Proposal announcements. $700
- Subscriptions to HIV-related publications. $450
- Printing and Reproduction expenses. $1,600
- Purchase project management software. $300
- Training/Seminar Fees Staff Development. $700

Planning Council: *$1,749*

- Office furniture, to purchase or replace office chairs $300
- Printing for an updated HIV Resources Guide. $300
- Training and Seminar Fees for staff development $300
- HIV Planning Council advertising in community media to recruit and increase Council membership and promote awareness/encourage involvement in Council activities. $849

Quality Management: *$2,800*

- Subscriptions to HIV-related publications. $800
- Printing and reproduction expenses of program materials such as surveys $900.
- Purchase project management software. $800.
- Quality Management Personnel training and Seminar Fees for staff development. $300

HIV Services: *$25,000*

Medical Transportation services provided in house through HHSD covers personnel and cost of bus passes, taxi vouchers, gas debit cards and special transit system passes. $25,000

Total amount $4,400,041

AUSTIN/TRAVIS COUNTY HEALTH & HUMAN SERVICES DEPARTMENT

Grant Period March 1, 2012 - February 28, 2013

Ryan White Part A FY 2012 LINE ITEM BUDGET

Budget Item	Salary	% FTE	Admin.	% FTE	Quality Management	HIV Services	% FTE	MAI Administration	MAI QM	HIV Services	Total
PERSONNEL											
Program Manager - Bolds	$74,922	0.10	$7,492	0.15	$11,238						
Grant Coordinator - Mendiola	$55,947	0.50	$27,973								
Grant Coordinator - Beck	$57,432	0.40	$22,973				0.08	$4,595			
Grant Coordinator - Garza	$58,917	0.35	$20,621				0.14	$8,248			
Financial Specialist - Chronis	$54,695	0.40	$21,878				0.10	$5,469			
Planner II - Vacant	$66,703	0.15	$10,005	0.50	$33,352		*0.32*				
Data Manager - Manor	$54,652	0.10	$5,465	0.50	$27,326		0.07		$3,826		
Quality Management Coordinator - Vacant	$74,192	*2.00*		0.80	$59,354		0.08		$5,935		
Community Services Program Manager-	$61,526	1.00	$61,526				*0.15*				
PC Planner II - Vacant	$53,040	1.00	$53,040								
Planning Council Administrative Assistant -	$29,257	1.00	$29,257								
		3.00									
Personnel Subtotal		*5.00*	$260,230	*1.95*	$131,270		*0.47*	$18,312	$9,761		$419,573
FRINGE											
FICA calculated at 6.2%			$16,134		$8,139			$1,135	$605		
Medicare Tax calculated at 1.45%			$3,773		$1,903			$266	$142		
Retirement-Salaries x 16% for 7 months and 18% for 5 months x 7.42.00 FTEs			$43,805		$22,097			$2,575	$1,508		
Medical Benefits 7 months x $10,239 and 5 months x $11,263 x 7.42 FTE			53,328		20,797			$2,991	$744		
Annual Stability Incentive Pay for 3.00 FTEs			$3,000		$1,500			$224	$105		
Fringe Subtotal			$120,041		$54,436			$7,191	$3,104		$184,772
Total Personnel			$380,271		$185,706			$25,503	$12,865		$604,345
TRAVEL											
Local Travel			$1,050		$800			$385	$79		
Out of Town Travel to Attend TGA/EMA Meetings and HRSA Sponsored Training/Meetings, e.g All Grantee			$13,500		$4,300						
Travel Subtotal			$14,550		$5,100			$385	$79		$20,114
EQUIPMENT											
Computer hardware purchased to replace absolete equipment			$1,100								
Rental of copier equipment			$3,280								
Equipment Subtotal			$4,380		$0						$4,380
SUPPLIES											
Food and beverages			$4,500								
Postage			$300								
Office furniture			$650								
Telephone Base Cost			$750								
Purchase Micro Projector			$435								
Office supplies			$1,281		$1,000						
Supplies Subtotal			$7,916		$1,000						$8,916
CONTRACTUAL											
Subcontracted Services						$3,494,995				$220,040	
Planning Council Parlamentarian Services			$1,500								
Training to promote and enhance motivational interviewing with multi-diagnosed clients to improve treatment adherence					$4,000						
Training to improve skills and knowledge of case managers working with PLWHA in the area of substance abuse and mental health					$3,400						
Specialized Quality Review of medical care, case management, substance abuse and mental health providers within the TGA					$5,052						
Contractual Subtotal			$1,500		$12,452	$3,494,995				$220,040	$3,728,987
OTHER											
Advertising of Public Notices for RFP			$700								
Subscriptions to HIV-related publications			$750		$800						
Printing and Reproduction expenses			$1,900		$900						
Training/Semminar Fees Staff Development			$600		$800						
Purchase project management software			$700		$300						
Advertising for PC Membership			$849								
Medical Transportation Services						$25,000					
Other Subtotal			$5,499		$2,800	$25,000					$33,299
GRAND TOTAL			$414,116		$207,058	$3,519,995		$25,888	$12,944	$220,040	$4,400,041
Function Percentage			9.41%		4.71%	80.00%		0.59%	0.29%	5.00%	100.00%

OMB Number: 4040-0007
Expiration Date: 06/30/2014

ASSURANCES - NON-CONSTRUCTION PROGRAMS

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

NOTE: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C.§§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U. S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee- 3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally-assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.

* SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	* TITLE
Leslie Boyd	Mayor
* APPLICANT ORGANIZATION	* DATE SUBMITTED
City of Austin Health and Human Services Department (HHSD)	11/01/2011

OMB Number: 4040-0010
Expiration Date: 08/31/2011

Project/Performance Site Location(s)

Project/Performance Site Primary Location ☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: City of Austin, Austin/Travis County HHSD

DUNS Number: 9456072650000

* Street1: 7201 Levander Loop, Building E

Street2:

* City: Austin County:

* State: TX: Texas

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 78702-5168 * Project/ Performance Site Congressional District: TX-010

Project/Performance Site Location 1 ☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name:

DUNS Number:

* Street1:

Street2:

* City: County:

* State:

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: * Project/ Performance Site Congressional District:

Additional Location(s) Add Attachment Delete Attachment View Attachment

CERTIFICATION REGARDING LOBBYING

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,00 0 and not more than $100,000 for each such failure.

Statement for Loan Guarantees and Loan Insurance

The undersigned states, to the best of his or her knowledge and belief, that:

If any funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this commitment providing for the United States to insure or guarantee a loan, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. Submission of this statement is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required statement shall be subjec t to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

* APPLICANT'S ORGANIZATION	City of Austin Health and Human Services Department (HHSD)
* PRINTED NAME AND TITLE OF AUTHORIZED REPRESENTATIVE	
Prefix:	Honorable
* First Name:	Lee
Middle Name:	
* Last Name:	Leffingwell
Suffix:	
* Title:	Mayor
* SIGNATURE:	Leslie Boyd
* DATE:	11/01/2011

ATTACHMENTS FORM

Instructions: On this form, you will attach the various files that make up your grant application. Please consult with the appropriate Agency Guidelines for more information about each needed file. Please remember that any files you attach must be in the document format and named as specified in the Guidelines.

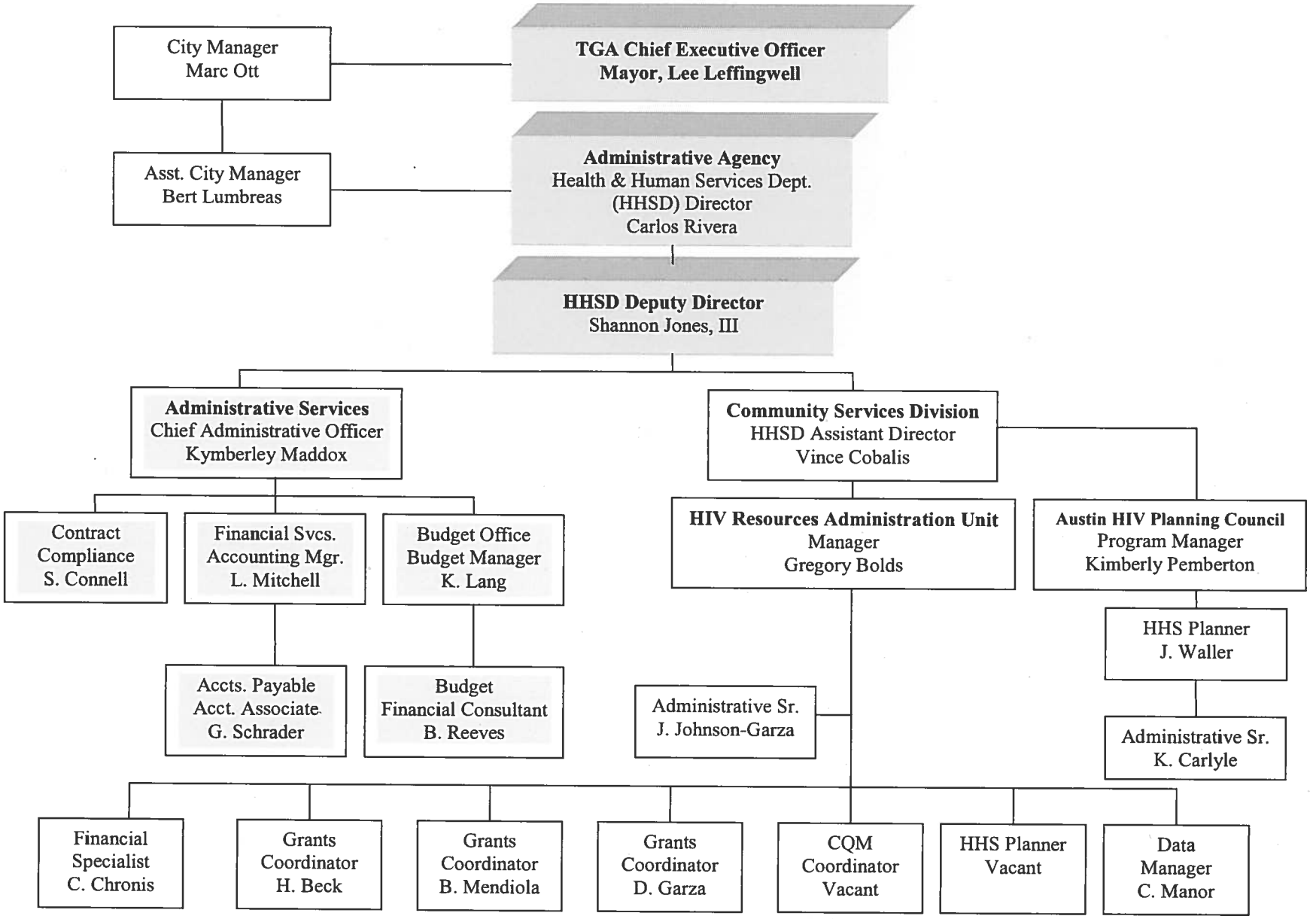
Important: Please attach your files in the proper sequence. See the appropriate Agency Guidelines for details.

1) Please attach Attachment 1	TableContentsOrgChartStaffin	Add Attachment	Delete Attachment	View Attachment
2) Please attach Attachment 2	LetterPCChairIGAAgreementsAs	Add Attachment	Delete Attachment	View Attachment
3) Please attach Attachment 3	HIVAIDSEpidemiologyTableFY12	Add Attachment	Delete Attachment	View Attachment
4) Please attach Attachment 4	ComorbiditiesTableFY12.doc	Add Attachment	Delete Attachment	View Attachment
5) Please attach Attachment 5	OtherPublicFundingTableFY12.c	Add Attachment	Delete Attachment	View Attachment
6) Please attach Attachment 6	UnmetNeedFrameworkFY12.doc	Add Attachment	Delete Attachment	View Attachment
7) Please attach Attachment 7	ImplementationPlanTableFY12.c	Add Attachment	Delete Attachment	View Attachment
8) Please attach Attachment 8	PlannedServicesTableFY12.doc	Add Attachment	Delete Attachment	View Attachment
9) Please attach Attachment 9	EIIHAMatrixFY12.doc	Add Attachment	Delete Attachment	View Attachment
10) Please attach Attachment 10	HIVTestingAwarenessDataFY12.c	Add Attachment	Delete Attachment	View Attachment
11) Please attach Attachment 11		Add Attachment	Delete Attachment	View Attachment
12) Please attach Attachment 12		Add Attachment	Delete Attachment	View Attachment
13) Please attach Attachment 13		Add Attachment	Delete Attachment	View Attachment
14) Please attach Attachment 14		Add Attachment	Delete Attachment	View Attachment
15) Please attach Attachment 15		Add Attachment	Delete Attachment	View Attachment

Table of Contents: Attachments

Attachment 1

Austin Transitional Grant Area (TGA) Organizational Chart



Staffing Plan, Position Descriptions, and Biographical Sketches

Note: Refer to Organizational Chart for placement in the organization. All positions funded by Ryan White Program Part A, including MAI, are listed. FTE percentage is indicated by Administrative Agency (AA), HIV Planning Council (PC), or Clinical Quality Management (QM).

	Name Job Title FTE %	**Job Description and Rationale for Amount of Time Requested**	**Education and Licensure Experience and Qualifications**
		Administrative Agency	
1.	G. Bolds Manager 10% AA	Responsible for the overall administration of Ryan White Part A program activities. Oversees and manages staff to ensure adherence to established policies. This position oversees and manages staff to ensure grant requirements are met, assesses the quality of services provided by subcontractors, and supervises data collection and quality management activities to ensure adherence to established policies.	B.A., Political Science; M.S., Urban Studies Over 29 years of experience in health and human services program planning and administration, including seven years in the Ryan White program. Extensive experience in program assessment and evaluation, data collection and analysis, research methods and performance measures development.
2.	B. Mendiola Grants Coordinator 50% AA	Responsible for coordination and preparation of the Part A grant application and preparation of grant post-award reports. Coordinates procurement process by preparing and processing RFAs. Prepares and negotiates grant subcontracts; assures compliance with terms of grant by monitoring subcontracts. Processes payment requests, and monitors and analyzes contract expenses.	Master of Social Work, M.S.W. Over 30 years of health and human services experience in administration, research, planning, and clinical services including 13 years of administering HIV grants and contracts. Former Manager, hospital-based Community Health Education Dept; Assistant Director, Stanford Urban Coalition; Research Associate and Counselor, Addiction Research Foundation.
3.	C. Chronis Financial Specialist 50% AA	Responsible for conducting all fiscal activities of the grant. Establishes and monitors program budgets; ensures all fiscal reports are submitted to HRSA. Develops grant-related documents for Austin City Council action. Coordinates grant closeout activities and end-of-year reports. This position monitors Part A grant and subcontractor expenditures.	B.A., Accounting General accounting experience in varied financial settings ranging from banking to hospital auditing and governmental systems, including 12 years supporting the Ryan White Part A program.

4.	C. Manor Data Manager 10% AA	Responsible for all data management tasks related to the Part A grant; provide training and support of subcontracts on client level data collection and manages the HIV services data reporting system (ARIES), including data quality. Prepares service utilization data reports for use in monitoring contractor programs, and for HIV Planning Council; also prepares required HRSA/HAB grant reports (RSR/RDR) and other administrative reports for the HIV Resources Administration Unit Manager.	B.A., major in English and minor in Business Management Over nine years of experience supporting the Ryan White program; proficient in the use of Microsoft Excel, Access, SPSS, and the ARIES client level software application.
5.	VACANT Planner II 15% AA	Develops and analyzes contract performance indicators to measure clinical care and support services. Collects and analyzes demographic, service utilization and outcome performance data in order to evaluate program effectiveness to ensure that program goals are accomplished.	VACANT
6.	H. Beck Grants Coordinator 48% AA	This position provides Part A grant contract management and monitoring for contracts and assists with grant reporting activities. Performs site visits, processes requests for payment, ensures contractor compliance with contract requirements, and provides technical assistance to service providers regarding contractual, performance reporting, and capacity-building issues.	B.A., Business Administration Over 19 years of HIV grants and contracts administration experience, with emphasis on contract monitoring including provision of technical assistance.
7.	D. Garza Grants Coordinator 49% AA	See description for #6 above. Also serves as lead on MAI grant program including preparation of grant application and preparation and submission of grant post-award reports.	M.P.A. (Public Admin.); B.S., RTF Communication Over 19 years of administrative experience, including management and program auditing, performance reporting, with additional expertise in public policy research and strategic planning.
		HIV Planning Council	
8.	K. Pemberton Program Manger 100% PC	Coordinates and supervises various aspects of the Planning Council's activities and mandated functions. Facilitates processes and ensures compliance with federal, state and local requirements. Supervises support staff. Oversees and manages the HIV Planning Council activities to ensure legislatively-mandated responsibilities are met.	Master of Public Administration (M.P.A.) Site Director for Urban League of Greater Chattanooga; Patient Service Representative for Hamilton County Health Department; counselor and Case Manager with Volunteer Treatment Center.

9.	J. Waller Planner II 100% PC	Supports Planning Council and its committees by collecting, analyzing, and interpreting epidemiological, programmatic and fiscal data and other information. Prepares reports for Planning Council.	B.A., Psychology Over 30 years of experience in health and human service program administration, including ten months as a Health Planner for Ryan White Part A. Managed a state Human Services office, serving as Project Director for Electronic Benefit Transfer (EBT) implementation and operation in two states.
10.	K. Carlyle Admin. Senior 100% PC	Performs administrative support functions for HIV Planning Council staff and members, including meeting/event planning, posting of agendas, preparing meeting minutes and assisting in preparation of reports and documents.	Candidate for B.A. in Psychology; Certified Pharmacy Technician Administrative experience; skill in computer software applications.
		Quality Management	
11.	VACANT QM Coordinator 88% QM	This position oversees the Part A QM program and tasks related to Part A QM program reporting. Facilitates activities related to design and implementation of QM Plan, selecting continuous quality improvement evaluators, initiating a comprehensive system to measure client satisfaction, and developing and implementing service-specific standards of care.	VACANT
12.	VACANT Planner II 50% QM	Research information and data as requested for QM planning and QI activities. Analyzes service utilization data and works in collaboration with QM Coordinator in developing, monitoring, and analyzing measures.	See #5 above.
13.	C. Manor Data Manager 57% QM	Responsible for all aspects of maintaining a comprehensive HIV Services data collection system that supports the QM program. Collates and processes QM data.	See #4 above.
14.	G. Bolds Manager 15% QM	See description in #1 above. Participates in Texas Ryan White Cross-Part QM Collaborative.	See #1 above.

The mission of the Austin Area Comprehensive HIV Planning Council is to develop and coordinate an effective and comprehensive community-wide response to the HIV/AIDS epidemic.

AUSTIN AREA COMPREHENSIVE HIV PLANNING COUNCIL

Mailing Address:
P.O. Box 1088
Austin, TX 78767

(512) 974-3419 *(office)*
(512) 974-2615 *(office)*
(512) 974-2409 *(fax)*
(512) 974-4400 *(HIV Info Hotline)*

WEBSITE
www.cityofaustin.org\hivcouncil

E-MAIL
HIVPlanningCouncil@gmail.com

Austin Area Comprehensive HIV PLANNING COUNCIL

October 20, 2011

Dr. Barbara Aranda-Naranjo, PhD, RN
Division of Service Systems
HIV/AIDS Bureau, HRSA
5600 Fishers Lane Room 7A-55
Rockville, Maryland 20857

SUBJECT: FY 2012 Planning Council Letter of Assurance

Dear Dr. Aranda-Naranjo:

The Austin Area Comprehensive HIV Planning Council experienced great challenges and rewards this past year. Fortunately, the rewards outweighed the challenges, thus enabling the Planning Council to successfully accomplish many key planning objectives throughout the grant year.

Building upon last year's momentum, the current FY 2012 grant application includes plans and activities that ideally not only meet programmatic and funding requirements, but exceed them as well.

As Chair of the Austin HIV Planning Council, I attest to the following assurances:

- FY 2011 Formula, Supplemental, and MAI funds awarded to the Austin TGA have been expended according to the priorities established by the Planning Council;
- All FY 2011 Conditions of Award relative to the Planning Council have been addressed;
- FY 2012 Priorities were determined by the Planning Council and based on an approved process of the Planning Council to establish said priorities;
- Planning Council annual membership training took place in various formats throughout the year; and
- Membership of the Planning Council is predominantly representative and reflective of the epidemic in the Austin TGA, with only two (2) representative slots vacant. A notable variation currently exists in the percentage of Hispanic consumers on the Planning Council in comparison to the Austin TGA prevalence of Hispanic individuals living with HIV/AIDS.

To address the membership vacancy issue of representation, as well as that of reflectiveness with regards to the non-aligned Hispanic membership base, the Planning Council will proceed with its annual targeted membership campaign which is conducted during the designated months of November through February. Past results of targeted membership recruitment have proven to be very effective. After last year's campaign, Planning Council membership increased over 50%. This year's recruitment goal is to increase the Hispanic representation by 12% (2 new members) and to fill the two (2) historically vacant slots of hospital planning agency and federal HIV grantees, including prevention services.

These are exciting times in Austin, Texas and I'm delighted to lead a dynamic group such as the Austin Area Comprehensive HIV Planning Council who has consistently proven its commitment to the community by listening, concurring, and acting on the issue of HIV/AIDS.

Respectfully,

Christopher Hamilton, MPH
Chair

and legally to all terms, performances, and provisions in this Agreement.

15.0 CONFLICT OF INTEREST

15.01 The parties shall ensure that no person who is an employee, agent, consultant, officer, or elected or appointed official of City or County who exercises or has exercised any functions or responsibilities with respect to activities performed pursuant to this Agreement or who is in a position to participate in a decision-making process or gain inside information with regard to these activities, may obtain a personal or financial interest or benefit from the activity, or have an interest in any Agreement, subcontract or agreement with respect to it, or the proceeds under it, either for him or herself or those with whom he or she has family or business ties, during his or her tenure or for one year thereafter.

16.0 INTERPRETATIONAL GUIDELINES

16.01 Computation of Time. When any period of time is stated in this Agreement, the time shall be computed to exclude the first day and include the last day of the period. If the last day of any period falls on a Saturday, Sunday or a day that County or City has declared a holiday for its employees these days shall be omitted from the computation.

16.02 Number and Gender. Words of any gender in this Agreement shall be construed to include any other gender and words in either number shall be construed to include the other unless the context in the Agreement clearly requires otherwise.

16.03 Headings. The headings at the beginning of the various provisions of this Agreement have been included only to make it easier to locate the subject matter covered by that section or subsection and are not to be sued in construing this Agreement.

CITY OF AUSTIN

By: _____ Date: 9/18/98
Kirk Watson, Mayor

TRAVIS COUNTY

By: _____ Date: 9/15/98
Bill Aleshire, County Judge

Appendix A

FY 2012 AGREEMENTS AND COMPLIANCE ASSURANCES
Ryan White HIV/AIDS Treatment Extension Act of 2009
Part A Grant Program

I, the Chief Elected Official of the Eligible Metropolitan Area or Transitional Grant Area, Austin, Texas, (hereinafter referred to as the EMA/TGA) assure that:

Pursuant to Section 2602(a)(2)[1,2]
The EMA/TGA will establish a mechanism to allocate funds and a Planning Council that comports with section 2602(b).

Pursuant to Section 2602(a)(2)(B)
The EMA/TGA has entered into intergovernmental agreements with the Chief Elected Officials of the political subdivisions in the EMA/TGA that provide HIV-related health services and for which the number of AIDS cases in the last five years constitutes not less than 10 percent of the cases reported for the EMA/TGA.

Pursuant to Section 2602(b)(4)
The EMA/TGA Planning Council will determine the size and demographics of the population of individuals with HIV/AIDS, as well as the size and demographics of the estimated population of individuals with HIV/AIDS who are unaware of their HIV status; determine the needs of such population, and develop a comprehensive plan for the organization and delivery of health and support services. The plan must include a strategy with discrete goals, a timetable, and appropriate funding, for identifying individuals with HIV/AIDS who do not know their HIV status, making such individuals aware of their HIV status, and enabling such individuals to use the health and support services. The strategy should particularly address disparities in access and services among affected subpopulations and historically underserved communities.

Pursuant to Section 2603(c)
The EMA/TGA will comply with statutory requirements regarding the timeframe for obligation and expenditure of funds, and will comply with any cancellation of unobligated funds.

Pursuant to Section 2603(d)
The EMA/TGA will make expenditures in compliance with priorities established by the Planning Council.

Pursuant to Section 2604 (a)
The EMA/TGA will expend funds according to priorities established by the Planning Council, and for core medical services, support services, and administrative expenses only.

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[1] All statutory references are to the Public Health Service Act, unless otherwise specified.
[2] The five new TGAs (Baton Rouge, Charlotte, Indianapolis, Memphis, and Nashville) are exempted from these requirements, but must provide a process for obtaining community input as described in **Section 2609(d)(1)(A)**.

Section 2604(c)
The EMA/TGA will expend not less than 75% of service dollars for core medical services, unless waived by the Secretary.

Pursuant to Section 2604(f)
The EMA/TGA will, for each of such populations in the eligible area use, from the grants made for the area under section 2601(a) for a fiscal year, not less than the percentage constituted by the ratio of the population involved (infants, children, youth, or women in such area) with HIV/AIDS to the general population in such area of individuals with HIV/AIDS, unless a waiver from this provision is obtained.

Pursuant to Section 2604(g)
The EMA/TGA has complied with requirements regarding the Medicaid status of providers, unless waived by the Secretary.

Pursuant to Section 2604(h)(2), Section 2604(h)(3), Section 2604(h)(4)
The EMA/TGA will expend no more than 10 percent of the grant on administrative costs, and in accordance with the legislative definition of administrative activities and the allocation of funds to entities and subcontractors, will not exceed an aggregate amount of 10 percent of such funds for administrative purposes.

Pursuant to Section 2604(h)(5)
The EMA/TGA will establish a CQM Program that meets HRSA requirements and that funding for this program shall not exceed the lesser of 5% of program funds or $3 million.

Pursuant to Section 2604(i)
The EMA/TGA will not use grant funds for construction or to make cash payments to recipients.

Pursuant to Section 2605(a)
With regard to the use of funds,

a. funds received under Part A of Title XXVI of the PHS Act will be used to supplement, not supplant, State funds made available in the year for which the grant is awarded to provide HIV-related services to individuals with HIV disease;
b. during the grant period, political subdivisions within the EMA/TGA will maintain at least their prior fiscal year's level of expenditures for HIV-related services for individuals with HIV disease;
c. political subdivisions within the EMA/TGA will not use funds received under Part A in maintaining the level of expenditures for HIV-related services as required in the above paragraph; and
d. documentation of this maintenance of effort will be retained.

Pursuant to Section 2605(a)(3)
The EMA/TGA will maintain appropriate referral relationships with entities considered key points of access to the healthcare system for the purpose of facilitating early-intervention services for individuals diagnosed as being HIV positive.

Pursuant to Section 2605(a)(5)
The EMA/TGA will participate in an established HIV community based continuum of care, if such continuum exists within the EMA/TGA.

Pursuant to Section 2605(a)(6)
Part A funds will not be used to pay for any item or service that can reasonably be expected to be paid under any State compensation program, insurance policy, or any Federal or State health benefits

program (except for programs related to the Indian Health Service) or by an entity that provides health services on a prepaid basis.

Pursuant to Section 2605(a)(7)(A)
Part A funded HIV primary medical care and support services will be provided, to the maximum extent possible, without regard to a) the ability of the individual to pay for such services or b) the current or past health conditions of the individuals to be served.

Pursuant to Section 2605(a)(7)(B)
Part A funded HIV primary medical care and support will be provided in settings that are accessible to low-income individuals with HIV disease.

Pursuant to Section 2605(a)(7)(C)
A program of outreach services will be provided to low-income individuals with HIV disease to inform them of such services.

Pursuant to Section 2605(a)(8)
The EMA/TGA has participated in the Statewide Coordinated Statement of Need process initiated by the State, and the services provided under the EMA/TGA's comprehensive plan are consistent with the SCSN.

Pursuant to Section 2605(a)(9)
The EMA/TGA has procedures in place to ensure that services are provided by appropriate entities.

Pursuant to Section 2605(a)(10)
The EMA/TGA will submit audits every two years to the lead state agency under Part B of Title XXVI of the Public Health Service Act.

Pursuant to Section 2605(e)
The EMA/TGA will comply with the statutory requirements regarding imposition of charges for services.

Pursuant to Section 2681(d)
Services funded will be integrated with other such services, programs will be coordinated with other available programs (including Medicaid), and that the continuity of care and prevention services of individuals with HIV is enhanced.

Pursuant to Section 2684
No funds shall be used to fund AIDS programs, or to develop materials, designed to promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual.

Lee Leffingwell
Signature

Date 10/10/11

Mayor of Austin
Title

Attachment 3

HIV/AIDS Prevalence and Incidence Data – Austin TGA

	AIDS INCIDENCE: 01/01/08 to 12/31/10		AIDS PREVALENCE as of 12/31/10		HIV (NOT AIDS) PREVALENCE as of 12/31/10	
	No.	**%**	**No.**	**%**	**No.**	**%**
Race/Ethnicity						
White	190	41.4	1,185	46.3	936	52.3
African American	98	21.4	629	24.6	381	21.3
Hispanic	157	34.2	713	27.8	448	25.0
Other	6	1.3	23	0.9	17	0.9
Sex						
Male	377	82.1	2,151	84.0	1,520	84.9
Female	82	17.9	410	16.0	271	15.1
Age						
<2 years	0	0.0	0	0.0	0	0.0
2-12 years	0	0.0	1	0.0	8	0.4
13 - 24 years	39	8.5	36	1.4	127	7.1
25 - 34 years	132	28.8	277	10.8	422	23.6
35 - 44 years	154	33.6	736	28.7	580	32.4
45-54	90	19.6	1,040	40.6	475	26.5
55+	44	9.6	471	18.4	179	10.0
Exposure						
MSM	293	63.8	1,552	60.6	1,258	70.2
IDU	41	8.9	346	13.5	122	6.8
MSM/IDU	34	7.4	237	9.3	118	6.6
Heterosexual	86	18.7	405	15.8	273	15.2
Pediatric	4	0.9	16	0.6	19	1.1
Other	2	0.4	5	0.2	1	0.1
Total	**459**	**100**	**2,561**	**100**	**1,791**	**100**

Source: *Texas Department of State Health Services* (eHARS as of July 2011, unadjusted for reporting delay. Cases with unknown risk have been redistributed based on historical patterns of risk ascertainment and reclassification. Other race/ethnicity includes Asian/Pacific Islander, Native American, Multi-Racial and other race/ethnicity cases. Column totals may not accurately sum due to rounding. Incidence rates are annualized for the three-year period).

Attachment 4

Co-morbidities – Austin TGA

Infectious Disease[1]	General Population		Persons Living with HIV/AIDS	
	N	Rate per 100,000	N	% PLWH/A Cases
Early Syphilis	246	14.4	52	1.2
White	98	10.6	25	48.1
African American	69	51.5	12	23.1
Hispanic	69	12.2	15	28.9
Other	5	5.8	0	0.0
Chlamydia	8,494	496.0	37	0.9
White	1,884	203.3	15	40.5
African American	1,534	1,144.7	10	27.0
Hispanic	3,238	571.9	12	32.4
Other	135	157.2	0	0.0
Gonorrhea	1,926	112.5	64	1.5
White	465	50.2	28	43.8
African American	552	411.9	14	21.9
Hispanic	622	109.9	22	34.4
Other	23	26.8	0	0.0
Tuberculosis	83	4.8	130	3.0
White	13	1.4	27	1.3
African American	7	5.2	53	5.2
Hispanic	50	8.8	49	4.2
Other	13	15.1	1	1.7
Hepatitis C	73	4.1	--	**25.0**
White	51	5.4	--	--
African American	2	1.5	--	--
Hispanic	15	2.5	--	--
Other	5	5.6	--	--
Homeless Persons[2]	**N**	**%**	**N**	**% PLWH/A Cases**
General population			--	--
Bastrop	104	--	--	--
Caldwell	49	--	--	
Hays	786	--	--	--
Travis	4,929	--	--	--
Williamson	1,184	--	--	--
Total	8,518	--	--	--
PLWHA	--	--	--	**5.1**

Persons no Health Insurance (19-64)[3]	**N**	**%**	**N**	**% PLWH/A Cases**
General population				
Bastrop	12,131	22.3	--	--
Caldwell	6,921	28.5	--	--
Hays	35,205	29.1	--	
Travis	169,632	24.5	--	--
Williamson	52,180	17.3	--	--
Total	**280,507**	**23.5**	--	--
PLWHA	--	--	--	**54.8**
Persons living at or below 300 percent of the 2011 Federal Poverty Level[4]	**N**	**%**	**N**	**% PLWH/A Cases**
White, not Hispanic	349,336	37.1	--	--
African American, not Hispanic	90,022	65.3	--	--
Hispanic	441,874	74.2	--	
Other & multiracial, not Hispanic	40,604	45.1	--	--
Total	**960,166**	**54.4**	--	--
Type of substance abuse[5]	**N**	**%**	**N**	**% PLWH/A Cases**
General population				
Any illicit drug use	288,827	21.3	--	--
Intravenous drug use	21,696	1.6	--	--
Heavy Alcohol	94,920	7.0	--	
Cocaine/crack	62,376	4.6	--	--
Marijuana	254,927	18.8	--	--
Psychedelics	33,900	2.5	--	--
Inhalants	10,848	0.8	--	--
Any illicit drug use	--	--	--	**75.3**
Injection drug use	--	--	--	**49.8**
Mental Illness Prevalence[6]	**N**	**%**		
General population				
Any mental illness	--	21.0	--	--
Schizophrenia	--	1.3	--	--
Any anxiety disorder	--	16.4	--	
Bipolar disorder	--	1.7	--	--
Severe cognitive impairment	--	1.2	--	--
PLWHA	--	--	--	**46.6**

[1] *Texas Department of State Health Services, 2011; Centers for Disease Control and Prevention, estimate of persons co-infected with HIV and HCV, 2011. Early syphilis includes primary,*

Secondary, Early Latent. Other race/ethnicity includes Asian / Pacific Islander, Native American, Multi-Racial and other race/ethnicity cases. Total number of STI cases includes cases with unknown race/ethnicity.

[2] *Helping America's homeless: emergency shelter or affordable housing, Washington DC, Urban Institute Press estimates applied to 2011 projected population; City of Austin / Travis County Health & Human Services Department 2007; Travis County Supplement to HIV/AIDS Surveillance 2001-2004.*

[3] *Texas Commission on Health & Human Services 2003 estimates applied to 2011 projected 19-64 year old population; Travis County Supplement to HIV/AIDS Surveillance 2001-2004.*

[4] *Federal Register, Vol. 76, No. 13, January 20, 2011, pp. 3637-3638; US Census Bureau 2009 American Community Survey Public Use Microdata Sample; & Texas State Data Center & Office of the State Demographer. Household size, income & race/ethnicity obtained for the state of Texas from the American Community Survey and were applied to 2011 projected TGA population.*

[5] *Texas Commission on Alcohol & Drug Abuse, 2000 Texas survey of substance use among adults prevalence estimates applied to 2011 projected ≥ 18-year-old population; Travis County Supplement to HIV/AIDS Surveillance 2001-2004.*

[6] *Mental Health: A report of the Surgeon General; Travis County Supplement to HIV/AIDS Surveillance 2001-2004.*

Attachment 5

Other Public Funding – Austin TGA

Categories	Ryan White Program not Part A		Other Federal Funds		State Funds		Local Funds		TOTAL FUNDS	
	FY 2011	FY 2012	FY 2011	FY 2012	FY 2011	FY 2012	FY 2011	FY 2012	FY 2011	FY 2012
Outpatient/ Ambulatory Medical Care	$1,231,142 14.06%	$1,210,859 13.82%	$0	$0	$136,021 6.78%	$136,021 6.78%	$1,017,499 39.24%	$1,048,024 40.44%	$2,384,662 14.10%	$2,394,904 14.11%
State AIDS Drug Assistance Programs	$7,003,287 79.95%	$7,003,287 79.96%	$0	$0	$378,195 18.84%	$378,195 18.84%	$0	$0	$7,381,482 43.64%	$7,381,482 43.47%
Home and Comm. Based Support Services	$101,287 1.15%	$126,221 1.44%	$2,438,767 68.58%	$2,504,620 69.15%	$275,700 13.73%	$275,700 13.73%	$972,684 37.52%	$939,939 36.27%	$3,788,438 22.39%	$3,846,480 22.65%
Other Outpt./ Comm. Based Primary Med Care	$115,330 1.32%	$115,330 1.32%	$0	$0	$89,000 4.43%	$89,000 4.43%	$87,849 3.39%	$87,849 3.39%	$292,179 1.73%	$292,179 1.72%
Oral Health Care	$238,177 2.72%	$232,940 2.66%	$0	$0	$0	$0	$0	40	$238,177 1.41%	$232,940 1.37%
Substance Abuse/ Mental Health Services	$70,000 0.80%	$70,000 0.80%	$329,666 9.27%	$329,666 9.10%	$77,959 3.88%	$77,959 3.88%	$0	$0	$477,625 2.82%	$477,625 2.81%
Minority AIDS Initiative (MAI)	$0	$0	$106,102 2.98%	$106,102 2.93%	$0	$0	$0	$0	$106,102 0.63%	$106,102 0.63%
HIV Counseling and Testing Services	$0	$0	$681,803 19.17%	$681,803 18.82%	$1,050,809 52.34%	$1,050,809 52.34%	$514,751 19.85%	$515,683 19.90%	$2,247,363 13.28%	$2,248,295 13.24%
TOTAL PUBLIC FUNDING	$8,759,223 100%	$8,758,637 100%	$3,556,338 100%	$3,622,191 100%	$2,007,684 100%	$2,007,684 100%	$2,592,783 100%	$2,591,495 100%	$16,916,028 100%	$16,980,007 100%

Attachment 6

Unmet Need Framework

	Population Sizes	Value		Data Source(s)
A.	Number of persons living with AIDS (PLWA), for the period of January - December 2010.	2,561		Cases from eHARS diagnosed and living as of 12/31/10; Cases diagnosed in Texas Department of Criminal Justice (TDCJ) removed and cases with unknown mode of exposure have been proportionately redistributed.
B.	Number of persons living with HIV (PLWH)/non-AIDS/aware, for the period of January - December 2010.	1,791		Cases from eHARS diagnosed and living as of 12/31/10; Cases diagnosed in TDCJ removed and cases with unknown mode of exposure have been proportionately redistributed.
C.	Total number of HIV+/aware for the period of January - December 2010.	4,352		
	Care Patterns	**Value**		**Data Source(s)**
D.	Number of PLWA who received the specified HIV primary medical care during the 12-month period (calendar year 2010).	1,999		Evidence of met need found in eHARS or through matches with AIDS Drug Assistance Program (ADAP), Ryan White program data (all Titles), or data from electronic laboratory reporting of viral load and CD4 results, Medicaid or private insurance medical care data.
E.	Number of PLWH/non-AIDS/aware who received the specified HIV primary medical care during the 12-month period (calendar year 2010)	1,258		Evidence of met need found in eHARS or through matches with ADAP, Ryan White program data (all Titles), or data from electronic laboratory reporting of viral load and CD4 results, Medicaid or private insurance medical care data.
F.	Total number of HIV+/aware who received the specified HIV primary medical care during the 12-month period (calendar year 2010).	3,257		
	Calculated Results	**Value**	**%**	**Calculation**
G.	Number of PLWA who did not receive the specified HIV primary medical care	562	22%	Value: Value A - Value D. Percent: Value G/ Value A
H.	Number of PLWH/non-AIDS/aware who did not receive the specified HIV primary medical care	533	30%	Value: Value B - Value E. Percent: Value H / Value B
I.	Total HIV+/aware not receiving the specified HIV primary medical care (quantified estimate of unmet need)	1,095	25%	Value: Value C - Value F. Percent: Value I / Value C

Source: *Texas Department of State Health Services*, 2011 using HRSA/HAB Unmet Need Framework Excel Worksheets.

Attachment 7

FY 2012 Implementation Plan

Service Priority Number: 6c		**Service Priority Name: Outpatient/Ambulatory Medical Care**			
Service Goal: Engage out-of-care PLWH/A and maintain in-care PLWH/A in system of care by providing full access to outpatient medical care and other eligible services. Care shall focus on: cultural competency, sensitivity, and proficiency; removal of existing barriers; and evidence-based strategies that target underserved and hard-to-reach populations.					
Objective:	**Service Unit Definition:**	**Quantity:**		**Time Frame**	**FY 2012 Funds**
		Projected Clients	Projected Units	3/1/12 to 2/28/13	**$1,151,809**
a. Provide outpatient primary medical care consistent with PHS/NIH/IDSA guidelines to existing and new HIV positive clients in the TGA.	Per visit	950	2,998		$929,380
	Per laboratory test	718	4,308		$222,429

Service Priority Number: 13		**Service Priority Name: Oral Health Care**			
Service Goal: Engage out-of-care PLWH/A and maintain in-care PLWH/A in system of care by providing full access to outpatient medical care and other eligible services. Care shall focus on: cultural competency, sensitivity, and proficiency; removal of existing barriers; and evidence-based strategies that target underserved and hard-to-reach populations.					
Objective:	**Service Unit Definition:**	**Quantity:**		**Time Frame**	**FY 2012 Funds**
		Projected Clients	Projected Units		
a. Provide diagnostic, preventive, and therapeutic dental services consistent with Standards of Care to existing and new eligible clients in the TGA.	Per visit	677	2,902	3/1/12 to 2/28/13	**$451,646**

Service Priority Number: 9b		**Service Priority Name: AIDS Pharmaceutical Assistance (local)**			
Service Goal: Engage out-of-care PLWH/A and maintain in-care PLWH/A in system of care by providing full access to outpatient medical care and other eligible services. Care shall focus on: cultural competency, sensitivity, and proficiency; removal of existing barriers; and evidence-based strategies that target underserved and hard-to-reach populations.					
Objective:	**Service Unit Definition:**	**Quantity:**		**Time Frame**	**FY 2012 Funds**
		Projected Clients	Projected Units		
a. Provide FDA-approved medications to existing and new eligible clients including those awaiting approval of ADAP or Compassionate Use Programs.	Per prescription	1,125	7,378	3/1/12 to 2/28/13	**$386,824**

Service Priority Number: 9c		**Service Priority Name: Mental Health Services**			
Service Goal: Optimize the continuum of care by ensuring all Ryan White funded services, particularly Mental Health Services and Substance Abuse Services, are of the highest quality and coordinated with non-Ryan White organizations for linkage to other funding sources.					
Objective:	**Service Unit Definition:**	**Quantity:**		**Time Frame**	**FY 2012 Funds**
		Projected Clients	Projected Units		
a. Provide mental health treatment and/or counseling services consistent with Standards of Care to existing and new eligible clients in the TGA.	Per visit	421	3,162	3/1/12 to 2/28/13	**$303,379**

Service Priority Number: 2b		**Service Priority Name: Medical Case Management (MAI)**			
Service Goal 1: Engage out-of-care PLWH/A and maintain in-care PLWH/A in system of care by providing full access to outpatient medical care and other eligible services. Care shall focus on: cultural competency, sensitivity, and proficiency; removal of existing barriers; and evidence-based strategies that target underserved and hard-to-reach populations. **Service Goal 2:** Optimize the continuum of care by ensuring all Ryan White funded services, particularly Mental Health Services and Substance Abuse Services, are of the highest quality and coordinated with non-Ryan White organizations for linkage to other funding sources.					
Objective:	**Service Unit Definition:**	**Quantity:**		**Time Frame**	**FY 2012 Funds MAI**
		Projected Clients	Projected Units		
a. Provide medical case management services consistent with Standards of Care to existing and new eligible clients in the TGA.	Per 15 minutes	50	2,393	3/1/12 to 2/28/13	**$60,000**

<table>
<tr><td colspan="3">Service Priority Number: 2a (Tier 1); 6a (Tier 2)</td><td colspan="4">Service Priority Name: Case Management Services Non-Medical (Part A and MAI)</td></tr>
<tr><td colspan="7">Service Goal 1: Engage out-of-care PLWH/A and maintain in-care PLWH/A in system of care by providing full access to outpatient medical care and other eligible services. Care shall focus on: cultural competency, sensitivity, and proficiency; removal of existing barriers; and evidence-based strategies that target underserved and hard-to-reach populations.
Service Goal 2: Optimize the continuum of care by ensuring all Ryan White funded services, particularly Mental Health Services and Substance Abuse Services, are of the highest quality and coordinated with non-Ryan White organizations for linkage to other funding sources.</td></tr>
<tr><td rowspan="2">Objective Tier 1:</td><td rowspan="2">Service Unit Definition:</td><td colspan="2">Quantity:</td><td rowspan="2">Time Frame</td><td rowspan="2">FY 2012 Funds Tier 1 $288,255</td></tr>
<tr><td>Projected Clients</td><td>Projected Units</td></tr>
<tr><td rowspan="2">Part A and MAI
a. Provide non-medical case management services consistent with Standards of Care to existing and new eligible clients in the TGA.</td><td rowspan="2">Per 15 minutes</td><td>Part A
199</td><td>Part A
10,299</td><td rowspan="2">3/1/12
to
2/28/13</td><td>Part A
$226,255</td></tr>
<tr><td>MAI
51</td><td>MAI
2,434</td><td>MAI
$62,000</td></tr>
<tr><td rowspan="2">Objective Tier 2:</td><td rowspan="2">Service Unit Definition:</td><td colspan="2">Quantity:</td><td rowspan="2">Time Frame</td><td rowspan="2">FY 2012 Funds Tier 2 $96,621</td></tr>
<tr><td>Projected Clients</td><td>Projected Units</td></tr>
<tr><td rowspan="2">Part A and MAI
a. Provide patient navigation services consistent with Standards of Care to existing and new eligible clients in the TGA.</td><td rowspan="2">Per 15 minutes</td><td>Part A
103</td><td>Part A
1,749</td><td rowspan="2">3/1/12
to
2/28/13</td><td>Part A
$32,000</td></tr>
<tr><td>MAI
27</td><td>MAI
3,533</td><td>MAI
$64,621</td></tr>
</table>

Service Priority Number: 4		**Service Priority Name: Substance Abuse Services – residential**			
Service Goal: Optimize the continuum of care by ensuring all Ryan White funded services, particularly Mental Health Services and Substance Abuse Services, are of the highest quality and coordinated with non-Ryan White organizations for linkage to other funding sources.					
Objective:	**Service Unit Definition:**	**Quantity:**		**Time Frame**	**FY 2012 Funds**
		Projected Clients	Projected Units		
a. Provide access to substance abuse treatment and/or counseling services in a residential setting to eligible existing and new eligible clients in the TGA.	Per 24-hour day	28	528	3/1/12 to 2/28/13	**$89,041**

Attachment 8

Planned Services Table

Priority	Core Medical Services	Amount
2b	Medical Case Management	$279,294
5	Health Insurance Premium & Cost Sharing Assistance	$99,128
6b	Early Intervention Services	$25,707
6c	Outpatient / Ambulatory Medical Care	$1,151,809
9a	AIDS Drug Assistance Program (ADAP)	$1,000
9b	AIDS Pharmaceutical Assistance – local	$386,824
9c	Mental Health Services	$303,379
13	Oral Health Care	$451,646
14	Substance Abuse Services – outpatient	$214,948
27a	Hospice Services	$77,673
27b	Medical Nutrition Therapy	$72,474
	Total Core = 81.9%	**$3,063,882**

Priority	Support Services	Amount
1	Medical Transportation Services	$25,000
2a	Case Management Services Non-Medical (Tier 1)	$288,255
4	Substance Abuse Services – residential	$89,041
6a	Case Management Services Non-Medical (Tier 2)	$96,621
9d	Outreach Services	$100,605
18	Psychosocial Support Services	$15,131
20	Food Bank / Home-Delivered Meals	$61,500
	Total Support = 18.1%	**$676,153**
	TOTAL SERVICES	**$3,740,035**

Attachment 9

Austin TGA EIIHA Matrix

ALL Individuals in Austin Transitional Grant Area who are Unaware of their HIV Status *(HIV Positive & Negative – Tested & Untested – Publically & Privately Tested)*						
Tested in the Past 12 Months			**Not Tested in the Past 12 Months**			
Individuals Not Post-Test Counseled *(HIV positive & HIV negative)*		**Received Preliminary HIV Positive Result Only – No Confirmatory Test**	**High Risk Individuals**			
Tested Confidentially	**Tested Anonymously**		**Young MSM Ages 13-34**	**Minority Injection Drug Users**	**Recently Released**	**African American Women**